WORK, ILLNESS, AND HEALING AMONG WOMEN WORKERS IN NONTRADITIONAL AGRICULTURE IN THE SAN FELIPE VALLEY, DOMINICAN REPUBLIC

By

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LAS GUERRERAS son las cuatro direcciones, las cuatro esquinas de un cuadrado, los cuatro vientos. La del Este, llamada orden, es optimista, suave, persistente como una brisa constante. El Norte, llmada fuerza, tiene recursos, es brusca, tenaz como el viento duro. El Oeste, llamada sentimiento, es introspectiva, taimada, como una ráfaga de viento frío. El Sur, llamada crecimiento, nutre, es bullanguera, animada como el viento caliente. Se reúnen todas sólo para realizar una tarea estrenua. Sólo en circumstancias muy especiales deben juntar sus manos: este contacto las fusiona en un solo ser.

(Agenda Papeles de Akelarre 1992-1993:148)

To the three winds of The Pandilla.

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Abstract of Dissertation Presented to the Graduate School
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WORK, ILLNESS AND HEALING AMONG WOMEN WORKERS IN NONTRADITIONAL AGRICULTURE IN THE SAN FELIPE VALLEY, DOMINICAN REPUBLIC

By

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Chairman: Allan F. Burns
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This dissertation analyzes work, illness, and healing strategies among women agricultural workers in the Southwest of the Dominican Republic. This study uses an organizing framework derived from the biocultural and medical pluralism models in medical anthropology as well as from women's constructions of causes of illness and their identification of healing choices. The present work is a woman-centric study situated within the field of women's health. Methodologically, this study has emphasized the importance of the ways in which women experience illness as an important component in the process of developing new knowledge in women's health.

A total of 111 women who work in the nontraditional agricultural export (NTAE) sector in the San Felipe valley were interviewed. The NTAE sector is a plan of development implemented throughout developing countries to address the economic

problems resulting from the economic crisis and structural adjustment policies of the 1980s. The new strategy of development consisted in diversifying agricultural production for export throughout the region. A feature of this economic strategy is its heavy dependence on low-cost female labor.

The sample of 111 women was constructed from the lists of employees and farmers of two companies located in the valley. The quota sample consisted of 38 women tomato pickers, 38 women banana packers, and 35 women agro-industrial workers. The women interviewed identified four major influences on their health status: paid work, social reproductive roles, environment, and economic conditions. Musculoskeletal problems associated with occupational settings emerged as the main health problem. Respiratory ailments, headaches, and fatigue-like symptoms were also found in high frequencies with respect to other health problems reported and were related to environmental, economic, and social reproductive influences.

At the level of healing choices, women indicated that they resort to home remedies and to self-care as the initial response to illness. The initial illness diagnosis is effected by the woman herself in the majority of cases followed by a health care provider such as a nurse or a physician. A lay person, either the woman herself or a relative followed by a physician from the public health care system, performs the initial consultation. It was found that women resort to a combination of health therapies and practitioners from both biomedicine and local medicine.

The findings of this study highlight the perception of illness and risk factors in relation to larger economic, cultural, and environmental conditions. This study brings to the forum the issues of women's health as workers in agricultural production and especially of women workers in developing countries as the new internationalization of

labor and food production requires low-cost female labor. The health conditions that the women described in relation to their workplace raises a new set of health issues about women's health in the Dominican Republic and adds a different set of health concerns to the public health agenda that has traditionally focused o women's reproductive health and fertility control. Finally, this study highlights the potential of pluralistic medicine as a low-cost health care alternative in the midst of limited health care resources.

CHAPTER 1
INTRODUCTION

The Problem

This dissertation is an exploration of both the social constructions of illness and the common-law union between biomedicine and local medicine among women agricultural workers in the San Felipe valley, Dominican Republic. It examines the ways in which women identify causal factors that affect their health and the ways in which they cope with illness. My analytical framework is derived from women's self-reported health problems in order to organize both the major elements of the illness experience and the coping strategies that women employ to confront illness.

The aspects of the illness experience that are examined in this work are (1) illness as the outcome of multiple forces shaping the individual as well as the collective experience of illness, and (2) the way in which individuals in local communities confront illness. These aspects are explored from the women's point of view to gain an understanding of their perception of the multiple forces that shape their health problems as members of a group that share similar work place, live in similar communities, and are influenced by similar cultural and socioeconomic forces. Furthermore, I explore the convergence of medical knowledge, rooted in the experience of peoples and communities, and medical knowledge that is the result of positivist scientific research,

the dominant medical paradigm in most contemporary Western societies. Merrill Singer and Hans Baer have noted that

> even folk healers who daily enter into trance to query spirit beings, concoct all manner of magical potions, and construct curious looking protective talismans in ministering to their clients, have been quick to recognize the healing power of biomedicine and either attempt to usurp its imagery or refer patients to its practitioners for supplemental treatment (1995:4).

Researchers have found that biomedical practitioners or physicians do not integrate several medical traditions as local healers often do. Studies about medical pluralism (the existence and utilization of parallel medical traditions) have shown that folk practitioners integrate elements of Western medicine with their local medical traditions (Oppong 1989). These studies did not find that in the context of Western medicine the integration of medical traditions was not observed (Leslie 1977; Cominsky 1983). However, the literature reports that biomedical[1] practitioners and researchers are increasingly interested in learning about patients' utilization of alternative medicine and its benefits (Eisenberg et al. 1993; Astin 1998).

Three questions guided data collection and analysis for this study:

(1) What is the relationship between women's health problems and their multiple productive (defined as remunerative and non-remunerative activities) and social reproductive (reproduction of families, households, and communities) roles?

(2) What are the health care resources available to women from the biomedical and local medical systems in the locales where they carry out their daily activities?

(3) How do women cope with illness?

---

[1] The terms Western medicine and biomedicine are used throughout this study to refer to the institutionalized health care, preventive and curative medicine provided to the population by both public and private sectors in hospitals and other centers by nurses, physicians, and other health care providers.

The data on which this study is based were collected utilizing a variety of methods. The larger portion of the data presented in this dissertation was gathered from a semi-structured health and work survey of 111 women. Other methods used during data collection include ethnographic observation and informal interviews with health care providers and local healers (see Chapter 3 for discussion of methods).

Anthropological research has been characterized by a commitment to conducting fieldwork. The fieldwork experience is the single most important component of anthropological research, for it is "being there", as Clifford Geertz (1988) describes it, what virtually distinguishes the discipline from other disciplines in social sciences. "Being there" for an extended period of time is a way to not only gather empirical data but to understand the context of the data gathered. With a telephone survey, for example, the context of the data is not so easily retrieved and the experiential authority, which is granted by virtue of attending to and participating in the daily events of the community or group of interest, is lost or never gained.

Perhaps one of the most common expected outcomes of fieldwork in anthropological research has been an ethnography, an extensive and detailed description and analysis of the people, community, or social group that the anthropologist chose to visit and study as they go about their everyday lives. This dissertation does not constitute an ethnographic study in the strict sense of the term and was not originally intended to be a detailed description and analysis of illness and healing practices among the population studied. However, this study utilizes ethnographic observations to nourish the context of the data generated with the other methods utilized during its collection. Ethnographic observations differs from an ethnography in that the former "means the collection of data

that describes a culture" as opposed to the description of a culture (Bernard 1995:16). The ethnographic principle of "being there" as a participant and observer of peoples and places constitutes an important component of the present work for it was this interaction with the people and the local setting how I became familiar with the features from the culture and the environment that later became relevant to the analysis and discussion of illness and healing practices among the women interviewed.

Increasingly, anthropological work is responding to specific issues within communities and groups. This problem-oriented and applied anthropology often resorts to a combination of methods that are not exclusively anthropological or ethnographic. This is especially true among medical anthropologists who are often members of multidisciplinary teams of researchers working with the common objective of improving the health care situation of peoples in different parts of the world (Pelto and Pelto 1991). This dissertation can be best situated within this research orientation. This study looks at a specific problem within a specific population utilizing a combination of methods of data collection that have long been used in social science research. Also, I engaged in field work that required collaboration with local NGOs and with a team of physicians working in the same geographical area where I was located providing both curative and preventive medical attention to the communities. The anthropological nature of my work lies on its reliance on people's point of view captured by the anthropologist in the natural settings were the participants carried out their daily activities. The most important component of this study is what the informants, consultants, participants, or the women interviewed (the term that I most commonly use during the discussion to refer to the people who became part of the sample) said about their health status.

Due to the subject of this study and the problem addressed in this dissertation, the reader might be misled to think that this study is a feminist work. Feminism has been characterized for a criticism to the invisibility of women in social science research and for a methodological critique to the dominant scientific paradigms. The critiques of positivism, to the presumption of objectivity, and to the idea of a value-free science have been important features of the feminist critique (Harding 1987; Gorelick 1996). At the core of feminist research there is also a quest for epistemological alternatives, for ways of knowing about the issues that surround and affect women in ways different from men. Feminist theory and method has informed my methodology and research design in that I have paid attention to what women, as the subject of study, have to say about their health problems as opposed to what national statistics indicate are their health concerns. However, I am not situating this dissertation within the parameters of feminist studies because I am not following the tradition of feminist methodologies and theories.

This study does not contain nor does it oppose a critique of positivism and objectivity. In this respect, and especially as it applies to the issues of this dissertation, it is my stance that there is great value in conventional scientific research and enormous contributions have been made from this standpoint to the improvement of the health of peoples and communities. In the same manner, the strong feminist challenge to conventional paradigms in biomedical research, for example, has revealed the bias inherent in scientific research which has resulted in treatments, standards, research designs, and pathologies that have been inappropriate to address women's health issues (Rosser 1994).

This study can be best described as a women-centric study (Rodriguez-Trias 1992) and more appropriately included in the new discipline of women's health (Dan 1994). The field of women's health is also growing as a multidisciplinary field where researchers gather their efforts to better understand women's health needs and implement better health care programs. Alice J. Dan states that

> The recent visibility of women's health issues is no accident but is based on the growing recognition that research and practice in medicine and health care generally have been based on male perspectives, which have allowed needs and concerns of women to be neglected. Women are no longer willing to look at studies of heart disease in men and wonder whether the findings will apply to them. They are no longer willing to be considered something other than "normal," as happens when a male norm is applied to them (1994:ix).

A woman-centric approach requires (1) a focus on issues that have critical impact on women, (2) a commitment to understanding women's experiences, (3) a serious recognition of the importance of women's experiences in the development of new knowledge on women's health, and (4) "the recentering of health relationships, away from the hierarchical model of the 'expert' professional who has all the knowledge to care for an ignorant patient, toward the recognition that the patient brings important information to the interaction and the the decision making needs to be shared" (Dan, Jonikas, and Ford 1994:389).

Why Women's Health

Researchers and international agencies have expressed the concern that more comprehensive analysis and empirical research are needed to understand how women's health is affected by multiple factors and socioeconomic roles (PAHO 1985, 1990; Dan 1994; IADB 1995). This dissertation is an effort to contribute to the understanding of

how women's health is influenced by multiple roles both in production and reproduction. Some examples of this research foci are Mereth Turshen's edited volume on Africa, Women and Health in Africa (1991), Alanagh Raikest's study on East Africa, Women's Health in Africa (1989), and Nancy D. Lewis' work on the Pacific Islands, Intellectual Intersections: Gender and Health in the Pacific (1998). These researchers have argued for a more comprehensive analysis of the causes of women's ill health. However, little empirical research exists that simultaneously (1) addresses women's definition of their health problems in relation to their multiple sociocultural, political, economic, and environmental factors, and (2) reports their strategies to cope with illness.

Increasingly, research in various health arenas such as nursing, community health, and health education attempts to understand individual attitudes and motivations for the purpose of planning and creating better prevention initiatives. In this respect, gaining an understanding of women's construction of illness causation and the health problems that they prioritize must be researched in order to benefit research agendas and programs designed to address women's health problems. Also, women may be the best segment of the population to consider in any program that aims to improve the health and living conditions of families and communities because of their multiple care-taking and working roles in the family. Studies have shown that at the household level women are the primary providers of health care (Finerman 1987,1989; Sánchez-Ayéndez 1993; Sargent and Brettell 1996). Moreover, women's labor is critical and dominant at the domestic level where they are responsible for the entire range of practical and basic needs necessary for the reproduction and maintenance of families and communities (Sen and Grown 1987; Moser 1993).

In the area of women's health issues, the majority of studies have emphasized women's reproductive behavior, fertility issues, population control, and maternal and child health (Browner and Sargent 1990). Consequently, women's biological reproduction has dominated a large portion of the research agenda on women's health. While these studies are unquestionably needed to determine the factors contributing to the creation of diseases that affect women, they have failed to account for the multiplicity of women's roles and how they impact women's health status, resulting in a partial epidemiological profile of women's health problems.

As a result of women's rights advocates redefining reproduction as a human rights issue (United Nations 1995c:65), a different emphasis is now being placed on women's reproductive health. However, studies report that less attention has been given to other dimensions of women's health such as women's health and the environment, work-related health problems or mental health issues (Jiggins 1994; Koblinsky et al. 1993; PAHO 1985). Emphasis on reproductive health, isolated from other health problems such as the effects of environmental dangers (e.g. pesticides and agrochemical agents) and other work conditions caused by agricultural, industrial, or domestic factors, or factors related to informal economic activities, provides only a partial picture of women's health issues. Health problems linked to the increasing number of female-headed households, informal economic activities, and reproductive work of women at the household and community levels add other dimensions to the definition of women's health, which are often neglected by scholars (Díaz and Schlaen 1994; de los Ríos 1993:15-16).

Currently there is a recognized lack of necessary information in order to assess women's health problems linked to their participation in the labor force (IADB 1995:29). This is particularly acute in the Caribbean and Latin America where there are few adequate health profiles of working women (PAHO 1985:152). The 1995 Fourth World Conference on Women brought the problem of the health of working women to the forefront and acknowledge that "occupational health issues are also growing in importance as large number of women work in low-paid jobs in either the formal or the informal labor market under tedious and unhealthy conditions" (United Nations 1995a:37).

Why Women's Health in the Dominican Republic

The Dominican Republic shares with neighboring countries a common history from the period of conquest and colonization, slavery, revolution, and emancipation to the most current political and economic history. Similar economic and social forces have shaped women's lives in the region (i.e. migration dynamics, structural adjustment policies). The Dominican Republic provides an excellent case study to examine the impacts of the internationalization of food production and the increasing dependence of this economic sector on female labor force as well as these impacts on micro levels such as women's health. Like the Dominican Republic, other countries in the region have also experienced these global economic changes. Secondarily, this study also provides an opportunity to examine how a particular population perceives the impacts of global processes on their lives and specifically, on their health status.

To accomplish the goal of this study, to examine women's health issues in the context of their multiple activities and to explore their health-seeking strategies, I chose to study women who work in the nontraditional agricultural export (NTAE) sector in the Dominican Republic. The NTAE sector is part of the US neoliberal economic policies of development implemented in Central America and the Caribbean by the US Agency for International Development (USAID) during the 1980s and early 1990s to invigorate national economies affected by the economic crisis and the structural adjustment policies of the 1980s (Conroy, Murray, and Rosset 1996). This economic sector has opened new work opportunities for women whose job choices are scarce and limited by educational levels and geographical location. Women's participation in the NTAE sector has increased as the requirements for cheap sources of labor force in areas such as harvesting, packing, and processing of fresh products have also expanded (Flores 1995a; Raynolds 1998). While the NTAE sector represents an economic solution for many families and communities, studies have shown that it has also brought about environmental degradation and illness (Murray 1994).

In the Dominican Republic and neighboring countries, the majority of those working in both production and processing are women (Raynolds 1998), which is a trend that has characterized the globalization of nontraditional food systems (Thrupp 1995:86-87). The growth of nontraditional agriculture and women's increasing participation in this economic sector provides an illuminating opportunity to explore the tensions between women's diverse economic and social roles in society and their levels of illness. This study offers the opportunity to explore the health ramifications of one of the most

current issues in women's insertion in paid economic activities in the global market, the feminization of employment in the NTAE sector (Lara 1995a; Raynolds 1998).

During nearly the past four decades anthropological and sociological research on women's issues in the Caribbean has been predominantly focused on issues of women's participation in the productive process, women's cultural subordination, female headed households, women in the free trade zones, and gender and development (Powell 1984; Safa 1986; Sen and Grown 1987; Safa 1995). Caribbean scholars have constantly examined the historical, political, cultural, and economic factors that have kept Caribbean women undercounted on national statistics, confined to traditional roles, and undermined them as mothers, wives, and housekeepers (Sen and Grown 1987; Beckles and Shepherd 1991; Safa 1995; Shepherd, Brereton, and Bailey 1995; Momsen 1993; McClaurin 1996; Springfield 1997). Most recently, Caribbean scholars interested in studying women's work have taken a more comprehensive approach to the study of women's economic contribution. These studies have redefined the work of women within households and communities as well as in the local and national economies by incorporating an analysis of women's productive and reproductive work (Safa 1995; Pou et al. 1987). However, in the Caribbean region, little research has been conducted on the consequences of these economic changes on women's health. Recent studies have examined the impact of the economic crisis of the 1980s decade and the economic transformations undergone by Caribbean countries on the overall health of families, especially children and mothers (Whiteford 1997). However, the challenge of examining the effects of women's social reproductive and productive roles on their health status has been outside of the scope of previous studies on Caribbean women's health.

Health issues of Caribbean women have been dealt with almost exclusively under maternal and child health programs and reproductive health (PAHO 1990; Sargent and Harris 1992; Johnson and Rogers 1993; Whiteford 1993). In the Dominican Republic, local NGOs and international agencies have similarly concentrated their efforts on prenatal care, child and maternal health programs, and reproductive health. Local organizations are also committed to enhancing women's skills and knowledge of community health and primary health care (CEPROS 1996). They address issues of domestic violence, mental health, and women's access to reproductive technologies, access to health services, and adequate sanitary conditions in their communities (Comprés 1997, personal communication; MUDE 1991; 1996).

Women's participation in the economy of the Caribbean and Latin America has dramatically increased over the past three decades (IADB 1995:22). Despite this change in the proportion of women engaged in productive work, health indicators related to working conditions are less frequent unavailable (PAHO 1985; IADB 1995). While the increased participation of women in the overall economic growth has been critical for the survival of their households, it has also added additional health problems. Combined with the social and cultural factors, this dynamic may result in disproportionate poverty and illness for women (Muller 1991).

Methodological Considerations: Towards a Multi-dimensional Approach

The theoretical and methodological approach used in this study attempts to address the limitations of the traditional definition of women's health, which has focused on women's biological reproductive functions. It also attempts to expand the framework

of current anthropological models of health and illness to emphasize women's experiences in the definition and determinants of illness, and in the understanding of routes pursued to regain health. Studies on women's health often focus on women's illness or healing therapies of local communities where women play a predominant role. It is less common to find studies that analyze both women's health problems and the actions which they take to face illness.

Women's construction of illness causation offers an illuminating perspective from which to explore the tensions between women's diverse roles in society and their levels of illness. The approach of this study is also a concrete effort to study women's health in a more comprehensive manner where the range of women's activities and roles are considered in defining women's health problems and the risk-factors identified in relation to the conditions reported. The data gathered in this study are centered on the experiences of the women interviewed and the manner in which they identified causal factors influencing their health status. The specific places where the women interviewed carry out their daily activities considered in this study are households, communities, agricultural fields, fruit packing areas, and processing plants. The women interviewed shared their experiences of illness these setting as workers, mothers, wives, sisters, daughters, and members of households and communities.

Summary

This chapter has stated the research problem of women's health within a framework that expands the traditional biological reproductive definition to include women's construction of illness causation as the outcome of multiple factors. It has also

stated that women's perspectives are necessary to expand the definition of women's health and to identify the dimensions that affect women's health status. By also including the actions taken by women to prevent, treat, or cure illness, this dissertation moves beyond traditional models in medical anthropology that address either the illness experience or the healing strategies.

In Chapter 2, I review relevant theories of health and illness in medical anthropology and situate this study within the biocultural model of health and illness (George Armelagos et al. 1992) and the concept of medical pluralism (Cominsky 1983). In this chapter I will also delineate the organizational framework that guides my discussion throughout the remaining chapters.

Chapter 3 describes the research design and methods, fieldwork setting, and sample characteristics. The local setting is placed into the general social and economic contexts of the Dominican Republic emphasizing the insertion of women as paid workers in nontraditional agriculture, the productive activity that dominates the economy of the San Felipe valley.

Chapters 4 and 5 contain the central discussion of this dissertation. Chapter 4 focuses on women's experiences of illness, and specifically on the health problems which they experienced 30 days prior to the interview with the aim of illuminating the health status of the population studied as well as the dimensions that women identify as shaping their illness experience. The concept of pluralistic causation will be introduced in this chapter to describe the way in which the women who were interviewed construct illness as a result of multiple and cumulative factors.

In chapter 5, I discuss the health care resources to which women resort in the

advent of illness. These include resources from biomedicine and local medicine. Because of the limitations of the biocultural model to fully address the simultaneous existence and utilization of healing choices, I employ the concept of medical pluralism to show that women utilize a combination of healing strategies to cope with illness.

Previous models in medical anthropology have dichotomized medical systems in traditional versus modern (Western) medicines. This dichotomization has suggested a progression in the medical knowledge and health-seeking behavior of individuals and communities moving from traditional to modern forms of health care. However, people's behavior and ways of living in contemporary societies clearly demonstrate that the lineal model does not explain the parallel or complementary co-existence of medical alternatives.

I must clarify at this point that in examining the ways in which the women interviewed confront illness through the utilization of different healing choices my intention was not to uncover curious rituals or religious symbols. The folkloric and religious aspects of sickness and healing have often been the focus of early anthropological research (e.g. Frazer's 1890 The Golden Bough; Evans-Pritchard's 1937 Witchcraft, Oracles, and Magic Among the Azande) and a description of such practices have consistently been included in traditional ethnographic work. However, this discussion is outside of the scope of the present study. The fact that a description of such beliefs and practices is not included in chapter 5 as I discuss the ways in which women confront illness by no means indicates that they are absent from the culture visited or that I did not encounter them during my fieldwork. In fact, one of the first stories that I was told upon my arrival to the research site was about a practice that consisted on sticking

needles in the body of a 7 year old girl by her grandmother with the believe that through this physical intervention in the girl's body a kind of sympathetic effect would be produced in another individual and the girl would be cured of a presumed condition that was not described by the informants. According to informants, the girl was later found at her home with 17 needles in her body and was taken to the children's hospital in critical conditions.

In chapter 6 I summarize the findings of this dissertation and highlight the key issues identified in this study. Finally, the chapter outlines the significance of these findings for future research in women's health studies in the Dominican Republic and the Caribbean and Latin America in general.

CHAPTER 2
WOMEN'S WORK, ILLNESS, AND HEALING: FORMULATING AN ORGANIZING FRAMEWORK

> ...la prueba de la teoría está en la praxis. Lo que quiero decir con esto es que, a la larga, cualquier teoría de la sociedad, y particularmente del cambio social, será estimada por su utilidad como instrumento de acción en manos de grupos sociales (Stavenhagen 1985[1971]:211).

> Theories mirror the values of those who utilize them. They are tools of knowledge, not of absolute truth. Their utility and capabilities to predict are subjected to the evaluation of history.

Introduction

As stated in Chapter 1, the aim of this study is to examine women's perspectives about how their health is influenced by a diverse array of risk factors and to explore the types of health care alternatives to which they resort to cope with illness. This study advances previous investigations on women's health issues in social sciences on two important counts. First, women's health issues in relation to their multiple roles in society are empirically explored. Researchers have pointed out that the definition of women's health needs to be expanded to incorporate the full length of women's lives and activities (Koblinsky, Campbell, and Harlow 1993:55; Bayne-Smith and McBarnette 1996). However, empirical research that explores these dimensions continues to be scarce in the Caribbean region. This study contributes to the body of research that empirically explores women's health issues in the context of their daily and ordinary lives and not in the context of discrete and isolated categories of disease. This goal is

accomplished through the description of self-reported health problems and the causal factors that the women interviewed identified in relation to the specific conditions that they indicated.

Second, this study utilizes a methodological approach that focuses on women's experiences to assess and delimit the dimensions of their health problems and their illness-coping strategies. This methodological approach consists of a combination of methods (a semi-structured questionnaire, ethnographic observations, and evaluation of published national statistics) to examine the connections that the women surveyed made between illness, risk factors, and places of exposure to risk factors and illness. The critical element of this methodological approach is what women's experiences of illness. This methodological perspective has also been identified as an area in women's health research that needs to be incorporated in the research agenda. This perspective also constitutes an alternative and complementary vision to traditional clinical, epidemiological, and social health research for better connections between the local context and institutionalized health care are needed to improve the well being of individuals and communities (Bair and Cayleff 1993; Dan, Jonikas, and Ford 1994). Women's individual and collective experiences are critical to understand the dimensions of their illness and their responses to ill health beyond the limitations of single life stories and the often static framework of epidemiological data in an effort to present an alternative analysis of women's health problems based on women's perspectives of their own illness.

This study also moves beyond the boundaries of past and current trends in anthropological studies on women's health studies in the Caribbean and Latin America.

Previous research has primarily focused on women as healers (e.g. McClain 1989; Koss-Chioino 1992), the cultural dimensions of women's biological reproduction throughout the life cycle (e.g. Sobo 1997), women's fertility in the context of development and population control, and child and maternal health (e.g. Sargent and Harris 1992; Johnson and Rogers 1993; Whiteford 1993).

A considerable number of anthropological studies about Caribbean women have been devoted to the examination of family patterns and the domestic unit (Bender 1967; Solien 1960; Brown 1977; Smith 1988), women head of households, women's productive and social reproductive activities, women's insertion in the labor force, and the debate on women's status and female subordination (Safa 1990, 1995). The new international division of labor that has made developing countries sites of production and suppliers of labor force has been another central topic in women's studies in the Caribbean and Latin America. These studies have focused on testing if women's entrance into paid labor force increases their status in society and if this process has effects on family structure and the traditional division of labor in the household. In contrast to these trends in studies about women in the Dominican Republic (Safa 1986; Finlay1989) and other parts of the Caribbean and Latin America, this study explores women's perspectives of the factors affecting their health status in the context of their multiple economic and sociocultural roles in society. Women's participation in the agro-export sector as paid workers is explored in the context of risk factors or influences affecting their health status.

The purpose of this chapter is to describe the organizing framework which guides the discussion contained in this study. This framework is based on (1) data collected on

women's construction of illness causation (the linkages that they established between their health problems and causal factors) and illness coping strategies; (2) the methodological approach that guided data collection which focused on the individual's point of view and the importance of women's perspectives in the definition of their health issues; (3) the biocultural model of health and illness; and (4) the concept of medical pluralism.

Two concepts are fundamental to the discussion of this dissertation. These are (1) what constitute women's work, and (2) how health is defined. For the purpose of this study, women's work is being defined as women's paid labor in agricultural activities and women's non-paid labor in the reproduction and maintenance of families and households (Aguiar 1985). The concept of health in this study refers to, in the broadest sense,

> the entire range of issues which touch on illness, sickness, disease, wellness, wellbeing as well as those activities of prevention, diagnosing, healing, caring, and curing. Health in this sense is a way of total wellbeing, which is not only determined by biological factors and reproduction, but also by effects of work load, nutrition, stress, war and migration, among others (van der Kwaak et al. 1991).

The definition of health utilized in this study is also concerned with the social experience and context for the assessment of multiple determinants of health and how health outcomes are formed and simultaneously affect the individual (Bloomberg, Myers, and Braveman 1994). Two other terms that are linked to the concepts of health and work need clarification; namely, health influences and risk factors. These concepts are interchangeably used in this study to refer to any situation, agent, or condition that was identified by the woman interviewed and associated with a current health problem or illness.

This chapter opens with a review of current trends in women's health research in the Caribbean and Latin America. It establishes the methodological coordinates of the problems on which this dissertation has been founded, namely the persistent need for a multi-dimensional perspective on women's health studies in the region, and the need for women's experiences to be genuinely included in research agendas that attempt to alleviate and eradicate pre-existing and emerging diseases and other health conditions that affect Caribbean and Latin American women as well as women in other parts of the world.

After I locate my research problem within this larger framework on women's health studies, I present the specific issues pertinent to the locality where I conducted my fieldwork. These issues are the interdependency between the local and the global agricultural economic contexts, global trends in agricultural production and labor force rearrangements, and women's increasing participation in the NTAE sector. The latter is a feature that has been a topic of increasing research on women's participation in the labor force in developing countries as the internationalization of food production searches for sources of cheap labor (Arizpe and Aranda 1986; Deere and León 1986; Flores 1993a; Raynolds 1998) creating an unequally symbiotic relationship of dependency between the parties involved.

A review of medical anthropology models opens the next section followed by further exploration of the theories pertinent to the dissertation analysis. Among the different models that medical anthropologists have developed (e.g., ethnomedicine, human ecology, critical medical anthropology, political economy) to analyze health and illness, I found that the biocultural model of health and illness (Armelagos et al. 1992)

and the concept of medical pluralism (Cominsky 1983) best served the purpose of this study.

This framework joins the biomedical model of health and illness, medical pluralism, the methodology that highlights women's perspectives and experiences in the construction of their own health and illness profile, the macro context of nontraditional agriculture which directly influences women's health, and other aspects in women's daily life that they identified as adversely influential on their health.

Trends in Women's Health Research in the Caribbean and Latin America

As previously stated, anthropological studies on women's health in developing countries have been dominated by an interest on issues of women's biological reproduction, as a result of the "proliferation of international public health efforts devoted to maternal and child health following World War II and the second wave of feminism that began in the 1960s" (Browner and Sargent 1990:217). Carole Browner and Carolyn Sargent define two bodies of literature pertaining to the anthropology of women's biological reproduction. The first set deals with "folk concepts of ethnophysiology and their relationship to reproductive, therapeutic, and ritual practices." The set second corresponds to "the structure of decision making and the consideration that informs reproductive choices" (1990:225). Scholars like Brigitte Jordan (1978) studied the cultural and physiological dimensions of the childbirth event, while Niles Newton and Michael Newton (1972) considered beliefs and behaviors associated with the stages of pregnancy and delivery in different cultures.

Some of the classical themes in the anthropological studies of women's health focus on the developmental cycle which is analyzed as both a biological and sociocultural event. Studies addressing menstruation, pregnancy, and menopause have often been the focus of early anthropological research on women's health. Initially, ethnographers focused on the ethnophysiological understanding of human biological reproduction with a greater emphasis on women's bodies (Browner and Sargent 1990); Elisa Sobo's (1997) study of menstrual traditions in Jamaica is an example of this anthropological tradition.

Critiques of this approach have pointed out that it has failed to consider the relationship between biomedical and folk concepts and understandings of biological reproductive events (Browner, Ortiz de Montellano, and Rubel 1988). Current cross-cultural studies on this topic challenge the biomedical construction of premenstrual, menstrual, and menopausal syndromes (Davis 1996). Other aspects of anthropological work on women's reproductive health in Latin America and the Caribbean include Carole McClain's (1975) study of Mexican mothers. In this study, McClain examined issues of compliance with injections during pregnancy. Lucille Newman's (1985) comparative study of women in seven societies over the world including Latin America focused on indigenous fertility regulation and women's use of medicinal plants is another example of this trend. Carole Browner (1986) also examined the utilization of herbal remedies to regulate fertility among Colombian women.

In addition, medical anthropologists have conducted cross-cultural studies about women's behaviors and attitudes regarding reproduction (Browner 1976) as well as issues of utilization of obstetrical services (McClain 1985). Sargent and Rawlins (1992)

conducted a study in Jamaica to explore issues of access, health-seeking patterns, and utilization of maternity services among low-income women. These studies focused on descriptive aspects of indigenous medicine and ethnophysiological concepts of women's biological reproductive health.

Medical anthropological studies in the Caribbean have examined the relationships between international economic policies on the health of women and children (Whiteford 1993; Johnson and Roger 1993). For example, Linda Whiteford (1993) has analyzed health and economic indicators in the Dominican Republic in order to explore the relationship between the economic crisis of the 1980s and the health status of women and children. She concludes that their health status has been affected by changes in dietary patterns, nutritional risk, incidence of infectious diseases, and mortality increase, unemployment, reduced wages, increased prices of basic commodities, and reduced government support for health care delivery.

International agencies working on women's health research in Latin America and the Caribbean have followed the predominant paradigm that examines women's reproductive behavior and their levels of fertility from a biomedical standpoint (PAHO 1985, 1990). Other factors such as socioeconomic status, employment opportunities, cultural factors, and political issues are also considered. However, they are placed in the context of biological reproduction as determinants of fertility levels and reproductive behavior for the assessment, development, and implementation of fertility programs and control policies (PAHO 1985).

Although research on women's health and illness continues to be confined most frequently to women's biological reproduction and fertility regulation, this approach was

recently broadened to include issues such as maternal health, reproductive-tract infections, STDs, and cancers of the reproductive organs (Koblinsky, Campbell, and Harlow 1993). The shortcoming of the biomedical standpoint is that it often neglects sociocultual factors, economic roles, and other health concerns in addition to women's reproductive system. Factors which all are equally important in defining and responding to women's health issues.

Various scholars have taken a further step to address women's health issues in a more comprehensive way. Increasingly, researchers are addressing women's health problems in relation to other aspects of women's lives such as their paid productive activities (Browner 1986), social reproductive roles, domestic violence (Finkler 1997), women's sexuality and environmental degradation (Jiggins 1994), and economic and social influences such as low wages, male migration, low-status occupations, and low educational levels (Browner and Leslie 1996). Although not exclusively reflective of the Latin America and Caribbean experience, some examples of the most recent trends in women's health research are found in the collection of interdisciplinary works by M. J. Koblinsky, J. Timyan, and J. Gay (1993), and Alice J. Dan (1994). The studies by Julia Mendel and Verónica Riquelme (1995), Ximena Díaz and Norah Schlaen (1994), and Deis Siqueira, Lourdes Beneria, and Mostafa Amin (1995) on work-related health issues are examples of current work that moves beyond the traditional biological definition of women's health. These later studies appeared as a response to women's working conditions in the new international division of labor. They are delimited to women's health issues in the workplace.

Most recently, postmodernist perspectives have provided an alternative framework to anthropological scholarship on women's health, especially in the domains of meaning, the body, motherhood, and pain (Martin 1987; Behar 1994; Good-Maust 1995). An example of this trend is Ruth Behar's story (1994) about the experience of a Mexican woman who had undergone a hysterectomy. This new scholarship, although framed within a fresh and radical standpoint, continues the traditional focus on women's biological reproduction initiated after World War II. Women's health studies, however, might not be an adequate terrain for the postmodernist emphasis in multivocalities and the denial of reality. The postmodern discourse can certainly illuminate women's health and illness processes by capturing nuances of individual experiences of disease. Nonetheless, the postmodern discourse may lead researchers to ignore critical aspects of women's health and illness (e.g. neglect to include female subjects in research trials, ways in which diseases differentially affect men and women, socioeconomic and political conditions) if all dimensions involved in the analysis of the causes of illness are considered as equally valid.

Despite the efforts and accomplishments of health organizations and researchers alike throughout more than three decades of continuous work in the Caribbean region and other areas addressing issues such as women's fertility, maternal and child health, and maternal mortality, the need for integrated perspectives persists; one that address women's health in the context of existing and emergent social, cultural, political, economic, and environmental pressures that affect women's health status and well being (Gómez and Gómez 1993; Dan 1994; Jiggins 1994.) Another aspect of current trends in women's research is the invitation to broaden the methodological perspectives to resolve

"inequities in health knowledge about and health care for women" (Dan, Jonikas, and Ford 1994). This invitation, born out of the recognition of women's exclusion from the decision-making process that targets their own health, requires a framework where women's perspectives and experiences of their own health conditions are considered (Heilbrum 1988; Gluck 1991; Young Samarasinghe, and Kusterer 1993). However, as many social researchers and feminist scholars have pointed out, the mere inclusion of women in the research agenda is not sufficient (Benería and Sen 1981; Moore 1988).

While in other arenas of women's studies this initial stage in the evolution of a scholarship about women has been moved forward from women's inclusion toward consideration of women's multiple and differing experiences and roles in societies around the world (Sacks 1979; Rosaldo 1980), advances in women's health research have moved at a slower pace. In the health arena, researchers continue to contest the basic inclusion of women in the research agenda as independent research subjects, the modification of research problems which are pertinent to women's health, the methodological procedures employed to collect and interpret data (Muller 1990; Rosser 1994), and the expansion of women's health definition from biological reproduction to include other dimensions of women's life such as productive and social reproductive work (Hatch and Moline 1997; Messing 1997).

Interdependent Contexts

One of the components of this dissertation is the economic context in which I have examined women's health issues. Women's health and illness in the San Felipe valley cannot be analyzed in isolation from women's economic participation in the

NTAE sector as paid workers. The increasing participation of female workers in nontraditional agriculture is not a random event but the result of larger economic processes in the reorganization of international food production and the new international division of labor which has virtually required a reconfiguration of labor force patterns (Raynolds 1998). The modification of the labor force structure to meet the demands of this economic sector have added an additional sphere of risk factors to the health and illness profile of women in this region and other parts of the world.

Nontraditional Agriculture in the San Felipe Valley

The Dominican Republic, as well as other Caribbean and Latin American countries, has experienced a process of expansion of economic sectors in an attempt to diversify and revitalize the national economic growth through the implementation of neoliberal economic models of development such as nontraditional agriculture. This developmental strategy followed the 1980's socioeconomic and political crisis and structural adjustment policies, and was implemented throughout developing countries in the region to stimulate national economic growth and stabilize sociopolitical conflicts.

In order to attain this objective, development planners implemented an economic strategy of diversification of agricultural production for exports supported by international financial agencies such as USAID and the World Bank as well as national governments (Thrupp 1995:3). The nontraditional agricultural diversification project promotes a variety of commodities with the objective of stimulating economic growth, repaying external debts, and reducing dependence on traditional crops such as sugar cane, coffee, and cacao (Thrupp 1995:3). The new commodities include crops such as

cantaloupes, pineapples, strawberries, broccoli, snow peas, and other frozen fruits and vegetables. Most of these crops are exported to the Unites States or European countries (Murray 1994). The factors that have stimulated the growth of the NTAE sector are:

> (1) changes in international trade policies and technologies;
>
> (2) shifts in dietary preferences and increased consumer incomes in industrial countries; and
>
> (3) greater penetration of transnational food companies in the South (Thrupp 1995:3).

Nontraditional agriculture includes export products that were not part of the agrarian history of the country, were produced for domestic consumption, or have been traditionally produced but are now been exported to a new market (Barham et al. 1992). In the case of the Dominican Republic, Laura Raynolds indicates that "[a]ccording to the major incentive laws (#409), Dominican nontraditional agriculture includes all fresh and processed exports <u>except</u> coffee, cocoa, tobacco, and sugar (and its derivatives and agro-industrial products for the home market" (1998:32). The term nontraditional agriculture does not describe a discrete group of agricultural products and is relative to the agricultural history of a particular country; what may be traditional in one country may be nontraditional in a different country (Barham et al. 1992).

The production of industrial tomato products and organic bananas in the San Felipe valley is included in the category of nontraditional agriculture. According to informants, San Felipe has been cultivating industrial tomatoes since the 1970s. The valley region is the main producer of all industrial tomatoes grown in the sub-region (INDESUR/GTZ and ONAPLAN 1994) with four tomato companies currently located in the valley. Two of these employ approximately 1,000 workers.

The cultivation of organic bananas appears to have a more recent history in the San Felipe valley although non-organic bananas and plantains have been traditionally grown in the Dominican Republic for national and export consumption. According to the owner of one organic banana company, the production of this commodity in the valley was initiated less than 10 years ago. The owner indicated that the company was established in 1993 and accounts for 50 percent of Dominican organic export banana production. This company also grows organic mango in addition to organic bananas and produces fruit puree. Two other organic banana companies are located in San Felipe, one of them highly unstable in the market. In 1987 San Felipe produced 19 percent of all bananas grown in the sub-region, but the proportion of organic bananas is unknown since available figures include the total production of both organic and non-organic bananas (INDESUR/GTZ and ONAPLAN 1994). At the time that the fieldwork for this study was conducted, other nontraditional crops such as okra, watermelon, and eggplants were being cultivated in the valley (IAD 1997).

Women's Labor in Nontraditional Agriculture

The NTAE sector has provided new opportunities for women, especially in the rural areas, who otherwise would opt for migrating to urban areas searching for employment (Mones and Grant 1987). The comparative advantage of women's labor, a consequence of their vulnerability and greater availability in the global labor market, has drawn a considerable number of women to the fields, packing areas, and processing plants as waged laborers (Arizpe and Aranda 1981; Flores 1995a; Raynolds 1998). The findings of this study show that women accounted for more than 50 percent of workers in

the packing areas in both banana companies located in the San Felipe valley with full operations (administrative, field, and packing operations). Women accounted for 44 percent of all workers employed in fruits and vegetables processing and packing operations in the company located in the valley with the largest number of workers. Previous studies in the same region indicate that women constitute 53 percent of workers in the processing of industrial tomato and that between 20 to 40 percent of workers in nontraditional agriculture are women (Raynolds 1998). However, researchers have consistently argued that women's economic participation in the Dominican Republic has been grossly underestimated (Safa 1986; Mones and Grant 1987; Báez and Taulé 1993). Alternative surveys, such as The Encuesta Nacional de Mujer Rural, one of the few existing surveys of rural women in the Dominican Republic, found that 68 percent of all waged women engaged in agricultural work were employed during the harvest season (Mones and Grant 1987).

Nontraditional agriculture as a strategy of economic development has been implemented in other countries as well. Similar to other projects of economic development (e.g. free-trade zones), women constitute an important portion of the labor force in the NTAE sector. The production of apples, nectarines, kiwis, grapes, and prunes in Chile, flowers and foliage in Colombia, Costa Rica, and Ecuador (Flores 1995b), and strawberries in Mexico (Arizpe and Aranda 1986) are some examples of nontraditional crops that have largely employed female labor.

After describing the economic context of women's work in agriculture in the San Felipe valley, the next section briefly reviews theoretical trends in medical anthropology. This review serves to place this study within the biocultural and the medical pluralistic

models that are better suited to understand the dimensions of women's illness and healing in San Felipe. It also serves to situate this research within the larger context of medical anthropological studies.

Review of Theories in Medical Anthropology

Traditional anthropological studies of health and illness have been concerned with the cultural as well as the biological interpretation of illness and healing, native medicine, and local healing practices. Based on non-Western societies where medical anthropologists have traditionally conducted research, post-World War II studies in medical anthropology often emphasized folk dimensions of illness and healing and biological and adaptational aspects of the illness experience. For example, studies conducted in the 1950s and 1960s were instrumental in advancing modernization programs implemented in developing countries. Ethnomedical models have been central to the cultural interpretation of perception, responses, and conceptualization of diseases among human groups (Fabrega 1975; Kleiman 1980). Biological models such as human ecology (McElroy and Townsend 1979) strongly influenced by epidemiological approaches, have been primarily interested in elucidating the relationships among host, pathogen, and the environment (Armelagos et al. 1992).

Turshen (1977) and Soheir Morsy (1979) have indicated that ethnomedical and biological/ecological models of health and illness in medical anthropology lack consideration of the political economy of health in the analysis of health and illness processes. Contrary to this position, anthropologists such as Singer and Baer have pointed out that the political economy standpoint "leaves one with the sense that local

conditions, cultures, and communities had no influence on the flow of events and direction of popular discourse" (1995:255). Medical anthropologists such as Margaret Lock and Nancy Scheper-Hughes (1990) were influenced by Morsy's proposal and Michael Foucault's writings on the body (individual body, social body, and body politic) (Lupton 1994), yet they were interested in maintaining the cultural dimensions of health, illness, and healing in their analysis.

In the 1980s, medical anthropology shifted its focus to the study of the culture of biomedicine. Influenced by theoretical trends such as Foucault's (1973) historical critique of modern medicine as an unbiased, unprejudiced system of knowledge, some medical anthropologists have examined Western medicine as a system of power (Good and Good 1993). Other anthropological models have emerged during the same period and have attempted to avoid the limitations of the biomedical model. First refined by Singer (1990), critical medical anthropology (CMA) is concerned with the interconnections between microlevels and macrocontexts, the influence of capitalist expansion on health-related issues, diseases as a social product, a critical examination of the context of biomedicine, and a commitment with praxis and social change. CMA emerged as a response to the shortcomings of conventional studies in medical anthropology. The latter lacked historical and theoretical perspective, did not address the political and economic contexts of health systems, and included a narrow understanding of social reality; also, it promoted medicalization.

The Biocultural Model of Health and Illness

George Armelagos and collaborators (1992) have proposed the biocultural model in medical anthropology to study health and illness in human populations. The biocultural model initially responded to the emphasis of ecological theories on behaviors as components of larger systems "functioning to maintain the system within adaptive limits", and to the failure to consider factors other than pathogens as disease-causing insults (Armelagos et al. 1992:38). The proponents of the biocultural model redefined three main features of the ecological perspective. These features are: the focus of study, the perception of the pathogen, and the perception of the environment.

The ecological model focuses on the individual as the carrier of disease, on the pathogen as the main cause of disease, and on the purely ecological and physical aspects of the environment (i.e. climate, topography, biotic elements, and geography) as factors that influence disease transmission. The biocultural model advanced this approach by defining the focus of study to consider individuals as actors, to include the choices they make, and the constraints placed on them. The perception of the pathogen moved from the agent as the primary cause of disease to other factors such as toxins, physical process, chemical pollutants, or psychological factors. The perception of the environment also includes political and economic forces, cultural factors, technology, and ideology.

The biocultural model integrates the ethnomedical and the biological perspectives in medical anthropology, two of the various models previously proposed to study health and disease. The authors submit that this model,

> 1) conceptualizes biomedicine as one of many worldwide ethnomedicines, that of Western cultures and empiricist scientific thought; 2) takes a behavioral approach by seeing populations, communities, classes, individuals (or other collectives) as "agents" operating within particular medical systems in a particular cultural and

> historical context; and 3) is reflexive in making clear the implications for an applied anthropology of health and disease that has as one of its larger goals the improvement of people's social and biological well-being.

This model is appropriate for the understanding of illness processes among the women interviewed because (1) it integrates ethnomedical and biomedical perspectives to understand illness and the responses to illness, (2) contrary to the ecological approach, it does not establish hierarchical relationships between the different causes of illness (biological, environmental, political, cultural, and economic), and (3) it considers individual's behavior in response to illness as taking place at macro and micro levels simultaneously affecting both the individual and larger social collectives.

While the biocultural model considers the political and economic context in which health and illness experiences as well as responses to ill events are occurring, some scholars have criticized the paucity of the political-economic critique in the analysis (Baer 1996). Because of the multilayered perspective of the biocultural model, the significance of political and economic issues might appear underestimated. This model, contrary to previous models in medical anthropology, addresses the different dimensions of illness -- from biological to cultural, from historical to socioeconomic – while it represents a strong analytical tool for the interpretation of health, illness, and healing processes in human societies. However, the critical importance of individual's perceptions in the definition of illness and illness causation is a dimension that lacks consideration in the model. For example, the authors apply the model to a contemporary Andean population to evaluate the "impact of illness on household work and production, and to examine the consequences on household work and responses to this impact" (Armelagos et al. 1992:43). They discuss the economic and environmental context of the

Peruvian region where the study was conducted, the political relationship of the population with the centralized government, the problems that the group faces to enter the regional markets and the growing dependency on poor wages and cash crops. After discussing the environmental, economic, and sociopolitical contexts, the authors discuss the impact of these processes on the health of the Andean group. However, during the discussion of illness it is not clear how individuals conceptualize their own illness processes. The authors administered a seasonal health survey to each family, but from the discussion of the results of the survey the experience of illness or the conceptualization of factors that result in illness is not clear, neither is it clear whether the authors were interested on the individual's construction of illness causation.

Medical Pluralism

Although the biocultural model looks at the healing alternatives to which an individual may resort to cope with illness, the model is not particularly designed to explore the individual's utilization of medical choices nor does it provide a concrete framework to examine them. In the biocultural model biomedicine is examined as another ethnomedical system. However, the model does not adequately address the issue of coping with illness simultaneously or serially with diverse medial traditions.

To address the shortcomings of the biocultural model to explain the simultaneous utilization of co-existent ethnomedicines, I have chosen Sheila Cominsky's (1983) model of pluralistic medicine. In discussing the characteristic of medicine and health care in Mesoamerica, Cominsky describes a pluralistic systems that includes

> (1) the existence of parallel or alternative systems from among which health seekers can choose – that is, pluralistic medical behavior on the

> part of the patient, and
> (2) the incorporation of elements from the different systems by practitioners or health providers, as well as by health seekers. These elements include disease categories, concepts of etiology, and treatment techniques (e.g., spiritists prescribing injections of penicillin or vitamins) (1983:159).

Other models exist such as Arthur Kleimans' (1980) tripartite scheme of popular, folk, and professional medicine where different health care sectors are described. However, as noted by Martha O. Loustaunau and Sobo (1997), Kleiman's tripartite scheme has its limitations where there are many different types of healers and therapies that fall outside of the definition of popular, folk, and professional sectors. In addition to this limitation, Kleinman's model does not adequately address the combination of ethnomedicines.

Formulating an Organizational Framework: Integrating Theory, Methodology, and Women's Experiences

The components of the organizational framework are:

(1) women's construction of illness which include the following influences on health or risk factors: living conditions, economic situation, and social and economic roles; and the physical contexts or place of exposure
- (a) workplace
- (b) communities
- (c) households; and

(2) the health care strategies to cope with illness.

This organizational framework is primarily concerned with exposing how women in the valley of San Felipe define factors that affect their health status, and how they utilize health care resources from biomedicine and local medicine to cope with illness. This analysis is guided by the biocultural model of health and illness, the concept of pluralistic medicine, and the methodological standpoint that calls for the integration of

women's experiences in the health research agenda.

The biocultural model addresses illness from both an ethnomedical and biomedical perspective. The model studies illness as the outcome of multiple insults such as technology, the cultural system, social organization, and the larger ideological system while Western and local medical systems are examined from the point of view of the agents using the systems (Armelagos et al. 1992:37).

However, the biocultural model, pays little attention to people's constructions of illness and their experiences in the definition of illness and their interaction with the medical systems to treat or prevent illness. Individuals appear to have little or no insights in the interpretation of the disease process. Because the model focuses on illness and not on the individual confronting illness, the biocultural model remains disconnected from and less grounded on people's perceptions or constructions of their own illness reality.

In the biomedical model, the way in which individuals treat or prevent illness through the orchestration of existing health care resources or healing alternatives is examined in the context of compliance with and adherence to Western medicine. Biomedicine is conceptualized as another ethnomedicine with no further examination of how individuals interact with the medical systems. The concept of pluralistic medicine is more useful to examine the reported utilization of both biomedicine and local medicine as complementary healing resources.

The variation of remedies and strategies employed by women to cope with illness can better be understood in light of the concept of medical pluralism. The integration of biomedical concepts and treatments by local practitioners is also a feature of pluralistic medicine. Local healers are eclectic. They adopt remedies and therapies as well as

diagnosis which have been given the patient by a biomedical practitioner. The local healer with knowledge of the disease etiology based on what the consultant has indicated proceeds to determine the therapy. This characterization of co-existent medical traditions and the interaction between the individuals and the health care resources provides a useful framework to understand the illness-coping strategies of the women interviewed.

Summary

This chapter has outlined the main theoretical and methodological components of this dissertation. It has placed this study within the traditions of studies in women's health, women's studies in the Caribbean, and major theories in medical anthropology. This chapter has described the economic characteristics of the fieldwork site as an important component of women's experience of illness. Major concepts such as health, work, illness influences, and risk factors were defined. The organizing framework for the analysis of women's perceptions of illness causation and their illness-coping strategies were also defined in this chapter.

I have incorporated the experiences and perspectives of women into anthropological theory by placing their perspectives at the center of the methodology utilized during and after data collection. I do not claim, however, in this analysis to present all shapes and tiers of women's experience of illness, but I do attempt to justly present all that the women of San Felipe kindly shared and as close to the original form in which it was presented as this analysis permits.

CHAPTER 3
RESEARCH DESIGN, SETTING, AND SAMPLE CHARACTERISTICS

Introduction

This research was conducted over a period of four months in the San Felipe[1] valley located in the Southwest of the Dominican Republic (Figure 3.1). The purpose of this study was to explore the relationship between women's health and their multiple productive and social reproductive roles and to examine the health seeking strategies available and/or created by women to prevent illness or regain health.

The study was conducted among women engaged in agricultural-related activities in the nontraditional agricultural sector in the San Felipe valley. This area was chosen because 70 percent of all nontraditional agricultural activities in the Southwest of the Dominican Republic are located in this valley (INDESUR/GTZ and ONAPLAN 1994). A larger portion of Dominican women find jobs in the manufacturing sector within the free trade zones, thereby motivating most of the research among women in the Dominican Republic (Joekes 1987; Safa 1995). Little, however, is known about women's entrance in the NTAE sector as waged laborers, and even less about the health ramifications of women's incorporation in Dominican nontraditional agriculture.

1 All names of places, agribusiness, local organizations, and people have been changed to protect the identity of those who generously volunteered their participation and collaboration in this study.

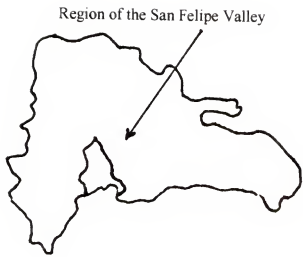

Figure 3-1. Sketch Map of the Dominican Republic

In the remainder of this chapter, I briefly describe the setting and the importance of the agrarian context where I undertook field work. This context is central to the issues discussed in Chapters 4 and 5. A description of the research design and methods of data collection utilized in this study follows the presentation of the setting and the agrarian context. Finally, I present an overview of the demographic and socioeconomic characteristics of the women interviewed.

Before the discussion of the methods employed in this dissertation, one issue needs clarification, and this is why race and racial identity are not discussed in this study. Conscientious of the history of migration between Haiti and the Dominican Republic that has contributed, among other forces, to current demographic patterns , my assumption was that the women who participated in this study were all Dominicans, of Dominican origin (at least one parent from the Dominican Republic), or born in the country from non-Dominican parents. My argument is not that the group of women that I surveyed is a homogenous groups in terms of race, but that they share a similar sociocultural and ethnic background as well as a national identity, that of being Dominicans. Almost everywhere one goes in the Dominican Republic one encounters the progression of colors from *negro* (black), to *indio oscuro* (dark indian), *indio claro* (light indian) or *blanco* (white) in the day to day conversations of people and in the ways in which Dominicans describe and identify other individuals. The exclusion of the issue of race if not because of omission, but primarily because it is outside of the parameters of this dissertation and the original research design. However, on theoretical and practical grounds in the development of current scholarship about women in the Caribbean, the issue of race is of special concern as scholars move a step further from the historiography on race to reveal

current patterns of inequality and social justice such as educational attainment and race, persistent labor market disparities and its relationship to race and gender, or the relationship between gender and the distribution of diseases and poverty in populations

The Province of San Felipe in the Context of the Dominican Republic

The province of San Felipe shares a similar political, cultural, and economic history with other provinces of the country and other parts of the Caribbean. The traditional plantation society was the model of socioeconomic and political development implemented at the time of colonization in the region (Matos González 1995). As part of a Spanish colony, San Felipe engaged in the production of sugar cane for export. The production of this commodity became the main economic activity during the 19th century (INDESUR/GTZ and ONAPLAN 1994). At the end of the 1990s, a similar system of agricultural production for export configures the socioeconomic and political development of the region. Although the commodities have changed over time, the basic economic arrangements of agricultural production have prevailed.

Like other regions in the country, San Felipe has been dramatically affected by the economic crisis of the 1970s and the 1980s structural adjustment policies established by international agencies such as the International Monetary Fund and the World Bank (INDESUR/GTZ and ONAPLAN 1994; Deere et al. 1990). The structural adjustments implemented during this period shifted the roles of the country's economic players. Industrial exports, mining, and tourism took the economic lead in the Dominican Republic while agricultural production suffered a dramatic decline (Murray and Hoppin 1992). The vagaries of international economic changes and increasing global

dependency have been felt more closely by the less economically fortunate segments of the population in San Felipe and in other regions in the country as well as neighboring nations that are largely dependent on agricultural production.

In order to cope with the economic shifts implemented by the globalization of production and flow of capital, states across the region addressed the situation through the diversification of agricultural production for export (Murray and Hoppin 1992). This strategy of economic development has been activated throughout developing countries at different periods during this century (Wolf 1982; Williams 1988; Conroy, Murray, and Rosset 1996). The new economic plan provided an answer to the low growth rates and the unemployment problems of the region. Nontraditional agricultural exports offered a possibility for the economic development of the valley of San Felipe and other regions in the Dominican Republic. A variety of crops such as eggplant, melon, okra, tomatoes, and oriental vegetables were introduced in the Dominican Republic as part of this nontraditional agricultural market (Murray and Hoppin 1992).

Within this context, San Felipe became the leading province in the production of industrial tomato in the Southwest region, although other crops such as pigeon peas, maize, beans, sorghum, and cassava, among others, have also been cultivated (INDESUR/GTZ and ONAPLAN 1994). More than half of the agribusinesses of the region are located in the San Felipe valley. They absorb 80 percent of investments in the sector and generate 76 percent of jobs in nontraditional agriculture (INDESUR/GTZ and ONAPLAN 1994).

Scholars have suggested that the new agricultural export sector, as well as other economic sectors, is heavily dependent on female labor (Standing 1989; Joekes 1987;

Flores 1995a; Raynolds 1998). This new economic sector has certainly taken advantage of the low cost and the intensive use of women's labor. Although the impacts of this process of restructuring of labor forces (Raynolds 1998) cannot be synthesized in simple terms, one aspect appears to be clear: the social costs of this process, including costs on health, seem to be heavier on the most vulnerable segments of the population who are dependent on the constant changes in the local and international economy.

While San Felipe stands out in the production of industrial tomato in the Southwest, the province belongs to one of the poorest regions in the country. The total population in San Felipe is 193,966, approximately 2.7 percent of the total population of the Dominican Republic, and it ranks third of the region's seven provinces with the highest population density (78.9 per square kilometer) (ONE 1996). Industrial growth is limited to only 5 percent of all industrial businesses in the country (mostly agribusiness) located in San Felipe (INDESUR/GTZ and ONAPLAN 1994). In 1994, half of the population in the region had a monthly income below poverty levels (DR$952.00 per family); this was the situation for only 28 percent of the general population (ONPLAN 1994). The province has one regional hospital with one bed per 1000 inhabitants, 24 rural clinics established by the public health system and distributed throughout the province that lack adequate equipment and services, and 5 other public health facilities, mostly located in the city (CONAPUFA/FNUAP 1995). This is in contrast with the national district of Santo Domingo where most of the public health services in the country are located (CONAPOFA/FNUAP 1995). General mortality and infant mortality rates are slightly higher in the Southwest, where San Felipe is located, for the period 1990 to 1995 than in any other region in the country (Table 3.1).

Table 3.1: Mortality Rates for the period 1990 to 1995

Regions	General Mortality Rates (per 1000)	Infant Mortality Rates (per 1000)
Southwest Region	6.5	61
Cibao Region	6.4	56
Southeast Region	5.5	56
Total for the Country	5.9	52[a]

Source: Atlas de Salud de la República Dominicana, 1995 and [a]Population Reference Bureau, 1996.

A local health care provider declared that San Felipe is like an "orphan with no parents in the government." On one of my daily trips on a motorcycle, the driver explained to me that San Felipe has been forgotten by the authorities, that people come, take, and go while leaving nothing behind (he was referring to investors in nontraditional agriculture, who are mostly from other regions, not from San Felipe). Whether each statement is true or false is not an issue of contention in this dissertation, but they are examples of public opinions that I frequently heard on the streets or read in the newspapers. What I found ironic is that San Felipe is located at midpoint between the capital city and the rest of the Southwest. Although it is a locality not easy to ignore or forget, San Felipe seemed to remain as a transient place.

Research Design

As indicated before, the San Felipe valley was selected because more than half of the nontraditional agribusiness in the region are located in this valley and because women comprise a growing segment of the labor force in this economic sector. This region was also selected after contacts were made with local Dominican NGOs working in the San Felipe valley. Originally, this study was concretized as a project to collaborate

with a local NGO in their efforts to study the health conditions of communities in the valley. This area represents a good example of what other regions may be experiencing as a result of the introduction of the NTAE sector as an economic alternative. To accomplish the objective of this research I selected a group of women who work in agricultural-related activities in the valley, all within the NTAE sector. The women selected worked as tomato pickers, banana packers, or agroindustrial workers (see Chapter 4 for a description of the labor activities of each group).

The region where this research was conducted is one of the areas in the country where nontraditional agriculture has increased over the last several decades, and it represents the single most important economic activity in the valley. Other crops, such as bananas, are ranked high in economic importance for the valley as well (IAD 1997). The geographical demarcations of this study were established based on the larger areas of industrial tomato and banana production (FECAINMAT 1997, personal communication). Industrial tomato and organic bananas are both grown in the lowlands.

I limited my sample to women residing in communities located in the valley. All of the women selected for the study who worked in the banana and the agroindustrial sectors were residents of communities located in the valley. In contrast, some of the tomato pickers moved from the highlands to the lowlands during the tomato season to harvest this crop. I only encountered one case in my sample of a woman who came from the highlands to the lowlands to work in the tomato harvesting. Six tomato pickers were residents of a community located in the transition zone between the lowlands and the highlands. This community, although not located geographically in the valley, has traditionally provided labor during the harvest of the tomato and other crops grown in the

valley, and it is considered economically part of the zone that comprises the valley.

Methods of Data Collection

(1) Health and Work Questionnaire: The data and results of this study are based primarily on 111 semi-structured interviews with women agricultural workers. I designed a health and work questionnaire to explore women's perspectives of the factors affecting their health status and the ways in which they cope with illness (see Appendix A). The questionnaire included questions on demographic and socioeconomic characteristics, health problems experienced by women 30 days prior to the interview, and the types of health strategies sought to treat or prevent illness either from the professional health care system or from local medicine (see Chapter 5 for definition of terms). This questionnaire was pre-tested with five Dominican women (two in Florida and three in the Dominican Republic) and modified to accommodate regional linguistic idiosyncrasies. interviewed most women in their homes, except for a small number of women who were interviewed in the banana-packing sheds. Most interviews lasted an average of 98 minutes although each visit to a woman's house took anywhere from 2 to 4 hours. Time was allocated for traveling and for locating each individual in her respective community. Traveling time was between 10 to 30 minutes depending on the location of the community with respect to the city. It took anywhere from 20 to 40+ minutes to locate a woman in her community depending on willingness of neighbors to cooperate or whether the woman was known by her birth name in her community.

(2) Ethnographic Observations: Ethnographic observations consisted on a general description of the communities visited, which also included visits to the local

clinic, and observations made at the tomato fields, the banana packing sheds, and the tomato processing plants. Field work in the valley of San Felipe also involved visits to the offices of the local peasant federation which, among other things, works with and provides technical support to peasants and communities in the production of crops in the province of San Felipe. I collaborated with them in the development of an agricultural survey for the federation. They informed me about the distribution of crops in the valley and the organization of production at the early stages of my field work. I also made regular trips to the city of Santo Domingo to meet with the NGO that granted me institutional support where I participated in a community health seminar and a conference on natural medicine.

At the time of my field work, this NGO was working on a health project with the peasant federation and women's groups in San Felipe. In these meetings we exchanged our field experiences about working with women in the valley. I also participated in several regional meetings of the Integrated Pest Management team where the conditions of tomato production and market as well as the effects of pests on the crops grown in the valley were discussed. This team was composed of agronomists, researchers in

agricultural production and pest control, agribusiness managers, representatives of the peasant federation and communities, and government representatives.

In addition, I participated in field trips with firm managers and agronomists to observe new techniques for tomato cultivation and pest control. These experiences gave me the opportunity to gain an appreciation of the socioeconomic and political issues that are daily debated in San Felipe, and of the parties involved in the discussion, debates, and development of action plans.

Constructing a Sample

My initial task in San Felipe was to develop a sampling frame to locate a group of women who were engaged in diverse types of agricultural work, yet were somewhat representative of other aspects of women's lives in San Felipe. Although national census data indicates that 489 women ages 10 to 65 of productive age are engaged in agricultural-related activities in the province of San Felipe (ONE 1996), researchers have found that women's participation in this economic sector in the Dominican Republic has been underestimated (Baéz and Taulé 1993). Furthermore, my interest was to explore illness accumulation from the perspective of the women interviewed, with the postulate that women's construction of illness could illuminate our understanding of the types of illness that affect women, the causes and morbid processes that lead to the production of ill health, and the illness coping mechanisms that they use.

Most of our knowledge on women's health issues is the result of biomedical paradigms which primarily focus on the diseases, not the individual, often as a discrete entity in isolation of larger social, political, cultural, and economic processes (Sargent and Brettell 1996). The utilization of women's experiences in the definition and ranking

of their own concerns in the health arena or any other sphere has been proposed by feminist researchers and health professional as "a fundamental organizing principle of women's health programs" (Brems and Griffiths 1993) to not only gain a better understanding of women's health concerns, but to genuinely improve their health status. I believe that traditional methodologies alone cannot elucidate the extent of women's health problems, including their own perception of vulnerability to their socioeconomic, political, and cultural surroundings. By incorporating women's construction of the causes and morbid processes that lead to the production of illness, researchers can reveal, beyond the statistics on prevalence and incidence, what it is that women regard as illness, as an abnormality in their bodies, or as pain, and act upon these utilizing both biomedical perspective and local knowledge.

I had established good rapport with agribusiness managers in the Valley of San Felipe during my previous work in the area in the summers of 1995 and 1996. One tomato company had given me access to their lists of employees and farmers to conduct my previous work in the region and had offered to assist me during my dissertation research. Although I collected a non-probabilistic sample, selecting the participants using a sampling frame allowed me access to women from diverse communities across the valley that I would have reached only through a more controlled sampling procedure.

I constructed a quota sample of women with the difference that individuals were not selected arbitrarily but randomly. By using this procedure, I attempted to obtain a sample that approximated the population of women working in agricultural-related activities. The selection of women through the companies' lists allowed me to reach many of the communities that supply labor to the NTAE sector. This help me gain an

appreciation of the locales in which women lived and other settings where women are exposed to conditions potentially adverse to their health status beyond their working place.

All of the locales of women's work and social life are certainly not represented in this study. However, by obtaining a randomized quota sample of women from the sectors where women's labor force predominate in nontraditional agriculture, I was more likely to generate a sample of women across the communities that supply workers to the agro-industries in the valley. With other non-probabilistic methods, such as snowball sampling or standard quota sampling, I was more likely to collect a sample that was not necessarily of women from the diverse localities in the valley that supply labor. I render this method the best way in which I could yield a sample through which I could gain exposure to women's multiplicity of productive and social reproductive roles in the diverse settings where they carry out their daily activities: work place, households, and communities.

I identified women in three of the agricultural activities in which they appear to comprise a large segment of the labor force in nontraditional agriculture in San Felipe (Raynolds 1998): crop harvesting, banana packing, and fruits and vegetables processing. As previously indicated, the last population census of the Dominican Republic shows that a total of 489 women in San Felipe were employed in agriculture and related activities (ONE 1996). The census figure, however, does not accurately reflect the large number of women who work throughout the year in crop harvesting. As noted by researchers and development agencies, women's participation in agriculture in Latin

America and the Caribbean is largely underrepresented in official employment statistics (Kleysen and Campillo 1996).

I established a quota of 40 women per agricultural activity. My objective was to interview 40 women in industrial tomato harvesting, 40 women in banana packing, and 40 women in fruits and vegetables processing and packing. The final sample, however, was composed of 38 women in tomato harvesting, 38 women in banana packing, and 35 women in fruits and vegetables processing and packing. The reasons for having a quota of less than 40 in all groups were: (1) seven women who were selected in the sample had migrated to other cities to work in domestic activities before I had the opportunity to visit them; (2) I could not locate or identify one woman because her names on the company's list of workers and the way she was known in their communities was different. Although I encountered this situation in several occasions, in only one occasions I also encountered community members' reluctance to identify her because of their suspicion of me and the purpose of my visit; and (3) in one case, the woman selected from the list had passed away after a car accident several months prior to my field work.

I structured the sample from the lists of farmers of one tomato company, and the lists of employees from one banana and from one tomato company. I visited the local companies to accomplish this goal. At the time of my field work, there were four tomato companies that grew industrial tomatoes in the San Felipe valley, but only two of them grew and processed industrial tomatoes for both local and export consumption. There were three companies that grew organic bananas for export in the valley, but only two of them had packing operations in San Felipe.

I was granted access to the list of farmers contracted and employees hired from the two tomato companies with full operations in the valley. One of the companies provided the lists of farmers. This company had the largest number of farmers contracted in the tomato production. The other company provided the lists of employees. This company had the largest number of workers employed.

I visited both banana companies, but requested access to the list of employees from only one of them. This was also the company that I contacted first, granted me access to their lists of employees, and volunteered logistic support in the field. This company also had the largest number of women employed. From each list of tomato farmers, banana, and agro-industrial employees, I constructed a sub-sample in each setting. I was very fortunate as a researcher to have obtained logistic support from the agribusiness as well as from the peasant federation. The agronomists greatly facilitated my entrance into the communities and finding the women in my sample.

The Selection of Women Tomato Pickers

To select the women who worked in the harvest of industrial tomato, I utilized the list of farmers contracted in the 1996-97 season from one of the tomato companies located in the Valley. I obtained this list from the company with the largest number of farmers on contract. Since tomatoes are cultivated during the months of October, November, and December and harvested in January, February, and March, I limited my selection to those farmers who had cultivated tomatoes in October and November and had harvested at least once during the months of January and February.

Farmers hire women and other workers for the tomato harvesting in an informal fashion. They keep a list with the names of the individuals who go each day of the harvesting period to work on their farms. The tomato harvesting on each farm lasts about 2 to 3 days and workers are paid at the end of each workday. The companies do not interact in the process of hiring workers for the tomato harvest, but they provide the farmers with a cash advance to pay the workers. This cash advance is deducted from the farmer's profit at the time of the liquidation at the end of the season.

I located the farmers with the help of the agronomists from the local company from which I obtained the list of farmers. I visited the farmers in their homes or their farms and explained to them the purpose of my visit and my work in the area. Nobody hesitated to provide the information I needed. I gained access to the lists of workers that farmers maintained. It was from these lists of workers that I constructed a sub-sample of 40 women working in tomato harvesting. In some instances the farmer had already "voided" (burned or thrown away) the list of workers by the time I visited them. When I encountered this situation, I relied on the farmer's memory to reconstruct the original list of workers they had hired to harvest the tomatoes. I confirmed the names on the list with the help of other workers who had collected tomato during the same period.

Farmers hire men, women, children, and elderly to work in the harvesting season. From these lists I selected all women who were hired by the farmers previously chosen and made a list from which I interviewed 38 women. The list from which I drew my sub-sample of tomato workers contained women of different ages, ranging from approximately 8 to 65 years. I did not know the age of the woman or the location of her community until I arrived at her house. Women who were 18 years or older were

selected. Single women with no children under the age of 18 were eliminated to comply with the regulations of the University of Florida Institutional Review Board which required that no minors were to be interviewed. Those who were between 15 and 18 and were either married, in a common law union, or single mothers, were selected. Women who were on the list of farmers and met the age criteria but were not living in a community located in the valley were not selected. The sub-sample of tomato pickers was made of 38 women residing in communities located in the valley.

The Selection of Banana Packers

This group of women was randomly selected from the list of female employees from the company with the largest number of workers employed in organic banana packing. The company had 67 women employed in the packing sheds. From this list I randomly selected 40 women and 38 were finally interviewed. This company immediately offered to assist me on my research. They provided copies of the lists of both male and female employees and the field supervisor volunteered to introduce me to the communities and the women who he supervised in the packing area.

These women were interviewed both in their homes and in the packing sheds. The supervisor of the packing area was instructed to let me interview the women during working hours. Eager to assist me in my project, he provided two chairs and accommodated us in an area next to the packing shed but quiet enough to not be disturbed by the noise of the workers. He took charge of bringing the women from the area where they were working to the area where they were being interviewed. This was not the procedure that I had initially planned to conduct the interviews. However, when I

visited the packing sheds to set up an appointment with the women, the supervisor was expecting me to work in the packing area and gave me the option of interviewing them in the working place. Women were paid for the time they spent with me. I accepted the offer on one occasion and interviewed six women. The remaining interviews were conducted in the women's houses. The sub-sample of banana packers was made of 38 women.

The Selection of Agro-industrial Workers

Agroindustrial workers were selected from the company with the largest number of employees. As with the other companies, access to the list of workers was granted in a friendly manner. The agribusiness manager was extremely helpful and granted me access to the company's list of workers to select the women. He also asked the supervisor of the packing and processing area to assist me in creating a list with the women's names and home addresses.

A total of 635 workers were employed during the week of February 17 to February 23. Of this total, 278 were women workers. This total was not fixed and was subjected to changes from week to week. These 278 women were distributed in different stages of processing and packing of fruits, vegetables, and legumes. From the list of 278 women I randomly selected 40 women and I interviewed 35. Each woman was interviewed in her house.

Demographic Characteristics of the Sample

Age Composition

As shown in Table 3.2, the mean age of all women interviewed is 34.9. The data on Table 3.2 reflect that the mean age for each group of women interviewed is not considerably different from the mean age for all women interviewed. The agro-industrial workers appear to have notably fewer women in the age group 15 to 24 (Table 3.2). It is important to point out that the mean age of tomato pickers does not reflect the large number of children who work in agriculture during the harvesting season. As stated before, when the woman on the sample was under the age of 18, single and with no children, she was eliminated from the sample thus purposely adding bias to the sample. It is clear that most women in the three working groups are concentrated in the 25 to 34 and the 35 to 44 age groups (Tables 3.2 ad 3.3). These are also the groups most likely to carry out multiple productive and social reproductive roles.

Table 3.2: Age Structure of All Women Interviewed (N = 111)

Mean = 34.9	Mode = 33	SD = 9.7	Range = 16 – 60
Age Groups		no.	%
15 – 24		16	14.4
25 – 34		46	41.5
35 – 44		30	27.0
45 – 54		15	13.5
55 – 64		4	3.6

Table 3.3: Age Structure of the Women Interviewed by Working Sector[a]

	Tomato Pickers (n = 38)		Banana Packers (n = 38)		Agroindustrial Workers (n = 35)	
Mean	34.3		33.5		36.9	
Mode[b]	22		33		32	
SD	10.7		9.0		8.6	
Range	44		38		34	
Min. – Max.	16 – 60		18 – 56		22 – 56	
Age Groups	no.	%	no.	%	no.	%
15 – 24	8	21.1	7	18.4	1	2.9
25 – 34	14	36.8	16	42.1	16	45.7
35 – 44	8	21.0	11	29.0	11	31.4
45 – 54	6	15.8	3	7.9	6	17.1
55 – 64	2	5.3	1	2.6	1	2.9

[a]Does not account for child labor.
[b]Multiple modes exist. The smallest value is shown.

Educational Status

Table 3.4 indicates that the mean number of years of school for all women interviewed is 3.6 with 0 years of school being the most frequent occurring value in the sample. These values, however, tell a different educational story when we look at the sample by working sector, and clear differences between the three groups emerge as reflected in Table 3.4.

Tomato pickers appear as the group with the lowest educational levels, followed by the agroindustrial workers and the banana packers respectively. It is interesting to observe that women with higher educational status are working in the areas where the NTAE sector requires more skilled workers. The data presented in Table 3.4 and 3.5 is consistent with global trends in the nontraditional agricultural sector where researchers have found that agribusiness prefer to hire women with relatively higher educational

levels on the premise that they constitute a better option compared to other prospects in the employment sector (Flores 1995a).

The socioeconomic vulnerability of the women who participated in this study restrains them to a limited selection of income-generating activities. Those with higher educational levels are more likely to find a job in the agroindustrial setting. Workers in the processing plant or the banana packing sheds have the benefit of a somewhat regular salary during at least 3 months at a time (the woman might be re-hired during other seasons during the year when they can and pack products such as maize, beans, and pigeon peas) in the processing plant and 12 months in the banana packing sheds, although not a secure job, and limited health benefits. Those with lower educational levels tend to be hired during the harvesting season as tomato pickers and are less likely to be hired in the banana packing sheds or the processing plant.

Low educational attainment appears to be a factor that limits the opportunities for better living and health status for all women interviewed. Job options for tomato pickers are even more limited than for any of the other two groups of women interviewed. The options are to harvest tomatoes, legumes, fruits, and other crops grown in the valley under inferior working conditions and poor wages, to work in the informal sector, or to migrate and work in the domestic sector in larger cities of the country. Women banana packers and agroindustrial workers have the same options as the tomato pickers in addition to their current jobs but can also work in the free-trade zones, which is the aspiration of many of the women who were interviewed.

Geographical Distribution

Another interesting aspect of the sample is its geographical distribution. Table 3.6 indicates that 75 percent of all women interviewed live in rural areas and 25 percent live in urban communities. Having a proportion of urban workers in the sample might not have been expected and may appear inconsistent with the traditional idea of "peasantry" and "agriculture", but is consistent with the current notion of nontraditional agriculture. Nontraditional agriculture was conceptualized in the midst of the regional economic crisis of the 1970s and the period of stagnation of the 1980s (Mathieson 1988). Given the characteristics of this economic sector – highly technological, diverse, and modernized, export-oriented, and large-scale production – it simultaneously attracts and needs a diverse labor force to furnish all segments of the productive process, which requires both skilled and unskilled labor. The last census figures for San Felipe (ONE 1996) show that women in the rural areas have higher levels of illiteracy and lower educational levels while women in the urban areas have higher educational status, which might make the latter more attractive for jobs that required higher skills levels. This leaves tasks such as tomato collection for individuals with lower educational levels.

The fact that the women interviewed who were from rural areas were employed in the harvesting season in the fields, as opposed to the packing or the processing plants, might also reflect the location of the stages of production. Most crops are grown in the rural areas, attracting workers from adjacent communities, whereas the processing plants are located at less than 5 minutes from the city by motorcycle. The processing plants attract workers from urban communities, but this is not necessarily a general trend since both urban and rural workers are hired in the agroindustrial sector. It appears that

educational levels of women are more likely to determine where they are able to find jobs within this economic sector.

Table 3.4: Educational Status: All Women Interviewed (N = 111)

Num. Yrs. School	no.	%
0	27	24.3
1	6	5.4
2	10	9.0
3	13	11.7
4	17	15.3
5	9	8.1
6	6	5.4
7	10	9.0
8	6	5.4
9	1	0.9
10	2	1.8
11	1	0.9
12	1	0.9
13	2	1.8
Mean	3.6	
Mode	0	
SD	3.6	
Range	0 - 13	

Civil Status

The women interviewed are largely in common-law unions as shown in Tables 3.8 and 3.9. There are no considerable differences in civil status by working sectors. This aspect of the sample appears to contradict recent literature on labor participation and civil status. Douglas T. Gurak and Mary M. Kritz (1996) conducted a comparative study on household composition and employment among Dominican women in New York and the Dominican Republic. The authors found that in the Dominican Republic, women living with a spouse or an adult man were less likely to be employed. The data presented in Tables 3.7 and 3.8 clearly show that the majority of women interviewed,

who were purposely selected from the pool of working women, were in some type of conjugal arrangement. The low number of single women, who in the sample collected for this study are either daughters or single mothers, might suggest that single women are migrating to urban centers in search of employment opportunities. This proposition would support studies on migration studies, which have found that urban growth has been accelerated by a rural feminine exodus (Duarte 1986; Báez 1988), a component of the configuration of urban centers in other regions of Latin America as well. Other options available to women with similar demographic features as the women interviewed are to work in domestic service or in the informal sector.

Table 3.5: Educational Characteristics of the Women Interviewed by Working Sector

	Tomato Pickers (n=38)		Banana Packers (n=38)		Agro-industrial Workers (n=35)	
Characteristics	no.	%	no.	%	no.	%
Num. Yrs. School						
0	17	44.7	3	7.9	7	20.0
1	4	10.5	1	2.6	1	2.9
2	2	5.3	3	7.9	5	14.3
3	6	15.8	3	7.9	4	11.4
4	4	10.5	9	23.7	4	11.4
5	0	0	5	13.2	4	11.4
6	1	2.6	2	5.3	3	8.6
7	1	2.6	6	15.8	3	8.6
8	1	2.6	3	7.9	2	5.7
9	1	2.6	0	0	0	0
10	0	0	1	2.6	1	2.9
11	1	2.6	0	0	0	0
12	0	0	1	2.6	0	0
13	0	0	1	2.6	1	2.9
Mean	2.1		5.0		3.9	
Mode	0		4		0	
SD	2.8		2.9		3.1	
Range	11		13		13	

Table 3.6: Geographical Distribution of All Women Interviewed (N = 111)

	no.	%
Rural	83	75
Urban	28	25

Table 3.7: Geographical Distribution of the Women Interviewed by Working Sector

	Tomato Pickers (n = 38)		Banana Packers (n = 38)		Agroindustrial Workers (n = 35)	
	no.	%	no.	%	no.	%
Rural	38	100	24	63	21	60
Urban	0	0	14	37	14	40

Table 3.8: Civil Status of All Women Interviewed (N = 111)

Civil Status	no.	%
Single	14	12.6
Married	4	3.6
Free Union	80	72.1
Separated	8	7.2
Widow	5	4.5

Table 3.9 : Civil Status of the Women Interviewed by Working Sector

	Tomato Pickers (n = 38)		Banana Packers (n = 38)		Agroindustrial Workers (n = 35)	
Civil Status	no.	%	no.	%	no.	%
Single	3	7.9	5	13.2	6	17.1
Married	0	0	0	0	4	11.4
Free Union	30	78.9	26	68.4	24	68.6
Separated	3	7.9	5	13.2	0	0
Widow	2	5.3	2	5.3	1	2.9

Socioeconomic Indicators

Income

Income figures are not utilized in this study as an indicator of well being. The reason for not including income data, although collected, is because household income is highly unstable and dependent on agricultural seasons. This is particularly true for rural families where members of household unit engage in multiple economic activities throughout the year to maintain and reproduce the household (Pou et al. 1987:33). In the work and health survey, tomato pickers reported earning an average of DR$40.63 pesos per day, the equivalent of US$3.12 dollars at the time that the field work was conducted. Women tomato pickers reported that they work on average 2.5 days per week during approximately three months. After this period some women work in the harvesting of other crops such as beans and maize, but these crops, contrary to industrial tomato, do not require a large number of workers, thus providing fewer job opportunities. It is likely that a large number of men and women, who might not have a job until the next season, might engage in informal jobs, or migrate to the cities.

Agribusiness managers indicated that their employees earn between DR$750 to DR$900 in the organic banana sector and up to DR$2,010 pesos per month in the agroindustrial sector. Women working in the banana packing sheds reported similar figures. Women working in the agroindustrial sector reported earning DR$10.5 per hour in an 8 hours working day, which is the minimum wage in the Dominican Republic. Women reported working between 2 to 7 days per week during three months, anywhere from DR$672 to DR$2,352 pesos per month. Women reported being frequently laid off or sent home after going to work because the fruits or vegetables had not arrived or

because the company did not need them for the day. This decreased the number of hours they could work per day. Agroindustrial workers such as the women interviewed are employed during 3 months at a time, which is the companies' strategy to lower the costs of production by avoiding employees' benefits. Job security in this system is dependent on the stability of the market, and women indicated that they might work anywhere from 3 to 9 months during the year. Some of the women employed in the agroindustrial sector indicated that they migrate to the city to work in the domestic sector, especially after the tomato season has ended and work in the processing plans lowers considerably.

Living Standards

The sample of women was collected in 22 different communities across the San Felipe valley. Living and sanitary conditions in these communities were not optional as I had the opportunity to observe and confirm with national statistics (ENDESA 1991), local and national newspapers (*El hambre no espera...a las calles ya'*, El Convite, enero 1997; *En Los Blocks y Las Salinas se carece de agua y salubridad, y la ayuda del gobierno no llega*, Listin Diario, abril 1997) and everyday life in the region. The mean household size for all units -- and each woman interviewed was a member of a household unit -- is 6.5 members (Table 3.10) with the same mean size across the three groups of women interviewed (Table 3.11).

Table 3.10 : Household Size: All Units (N = 111)

Mean	Mode	SD	Range
6.5	6	2.8	2 – 15

Table 3.11: Household Size by Working Sector

	Tomato Pickers (n = 38)	Banana Packers (n = 38)	Agroindustrial Workers (n = 35)
Mean	6.5	6.5	6.4
Mode	4[a]	6	6
SD	3.1	2.8	2.5
Range	2 – 15	2 – 14	2 – 11

[a] Multiple modes exist. The smallest value is shown.

Table 3.12 illustrates that 67.6 percent of the households have access to sanitary services, with an individual latrine named as the most common type of facility for 45 percent of the households. As shown in Table 3.13, considerable differences exist between tomato pickers, banana packers, and agroindustrial workers households. For 55.3 percent of the tomato pickers households there is no access to sanitary facilities whereas this is the case in only 15.8 percent of banana packers and 25.7 percent of tomato pickers. For the three groups with access to sanitary services, however, an individual latrine is the most common type of sanitary facility.

Table 3.12: Access to Sanitary Facilities: All Households (N = 111)

	no.	%
Sanitary Services		
Yes	75	67.6
No	36	32.4
Type of Sanitary Services		
Individual toilet	21	18.9
Individual latrine	50	45
Collective latrine	4	3.6
None	36	32.4

Table 3.13: Access of Sanitary Facilities by Working Sector

	Tomato Pickers (n = 38)		Banana Packers (n = 38)		Agroindustrial Workers (n = 35)	
Sanitary Services	no.	%	no.	%	no.	%
Yes	17	44.7	32	84.2	26	74.3
No	21	55.3	6	15.8	9	25.7
Type Sanitary services						
Individual toilet	4	10.5	11	28.9	6	17.1
Individual latrine	10	26.3	21	55.3	19	54.3
Collective latrine	3	7.9	0	0	1	2.9
None	21	55.3	6	15.8	9	25.7

Propane gas is the most common source of cooking fuel for all women interviewed as illustrated in Table 3.14. However, for the tomato pickers the most common source of cooking fuel is firewood (Table 3.15). Propane gas is the main source of cooking fuel for both the banana packers and the agroindustrial workers. As shown in Table 3.14, potable water is available to 68.5 percent of all households. However, percentages are different across working groups: 52.6 percent of tomato household, 76.3 percent of banana households, and 77.1 percent of agroindustrial households have access to potable water. Almost all households have access to electricity regardless of working sector (Tables 3.14 and 3.15). Electricity, however, has been "made available" in almost all households by the people in their communities through "bootleg" electrification systems.

Access to land is an important component of the economy in San Felipe. Of all women interviewed, 41.4 of their households have access to land. The most common type of land acquisition is as beneficiaries of the agrarian reform sector (Table 3.16).

Table 3.14: Cooking Fuel, Access to Electricity and Potable Water: All Households (N = 111)

	no.	%
Cooking Fuel		
Propane gas	72	64.9
Firewood	39	35.1
Electricity		
Yes	105	94.6
No	6	5.4
Access to Potable Water		
Yes	76	68.5
No	35	31.5

Table 3.15: Cooking Fuel, Access to Electricity, and Potable Water by Working Sector

	Tomato Pickers (n = 38)		Banana Packers (n = 38)		Agroindustrial Workers (n = 35)	
	no.	%	no.	%	no.	%
Cooking Fuel						
Propane gas	17	44.7	30	78.9	25	71.4
Firewood	21	55.3	8	21.1	10	28.6
Electricity						
Yes	35	92.1	36	94.7	34	97.1
No	3	7.9	2	5.3	1	2.9
Potable water						
Yes	20	52.6	29	76.3	27	77.1
No	18	47.4	9	23.7	8	22.9

This is the only economic indicator where the tomato pickers ranked higher compared to the banana packers and the agroindustrial workers (Table 3.17). An interesting finding to accentuate is that of this 52.6 percent of tomato pickers with access to land, 13.2 percent indicated that those are "recovered" or "invaded" lands. If we use the language of the peasant organizations and the people in the communities we speak of recovered lands; if we use the language of the landowners, government authorities, and agribusiness managers, then the land has been invaded.

Table 3.16: Access to Land: All Households (N = 111)

Land Ownership	no.	%
Owns land	46	41.4
Does not own land	65	58.6
Land Acquisition	**no.**	**%**
Agrarian reform	23	20.7
Inherited	10	9.0
Sharecropped	3	2.7
Purchased	4	3.6
Recovered/Invaded	5	4.5
No land	65	58.6
Missing data	1	.9

Table 3.17: Access to Land by Working Sector

	Tomato Pickers (n = 38)		Banana Packers (n = 38)		Agroindustrial Workers (n = 35)	
	no.	%	no.	%	no.	%
Land Access						
Yes	20	52.6	19	50	7	20
No	18	47.4	19	50	28	80
Land Acquisition	no.	%	no.	%	no.	%
Agrarian reform	8	21.1	12	31.6	3	8.6
Inherited	4	10.5	5	13.2	1	2.9
Sharecropped	2	5.3	0	0	1	2.9
Purchased	0	0	2	5.3	1	5.7
Recovered/Invaded	5	13.2	0	0	0	0
No land	18	47.4	19	50	28	80
Missing data	1	2.6	0	0	0	0

Data Collection Tales

Most of the interviews were conducted in rural communities (75%). The urban barrios that I visited were originally shantytowns made from small cardborad houses. Some areas of the communities continue to be characterized by the marginal conditions of shantytowns: cardboard, palm tree, or mud houses, no electrification or water, no sanitary services, and high poverty. According to informants, these communities were

formed by people who migrated from the rural areas, and especially from the highlands, to the city searching for opportunities to improve their living standards. One of the communities, *Los Cartones*, is named after the original houses that were built in the area from cardboard.

My random sample directed me to a total of 22 communities throughout the valley. The first time I went to each community I was accompanied by an agronomist from one of the companies that supported my research. Knowledge of the local language and cultural, historical, and phenotypical resemblace with my Dominican neighbors was certainly on my side and facilitated my entrance to the communities. My gender was another factor that also contributed, knowing from my personal experience growing up in a Caribbean country, how cultural views portray females as helpless and defenseless individuals who need male protection. Scenes of men helping girls, young, or elderly women were commonly seen on the bus, the streets, and the neighborhoods. In one occasion coming from San Felipe to the city on the bus I saw how a young mother "demanded" that the young man standing by the door helped her getting off the bus. She had a baby, a stroller, and a few bags and told the young man in a strong voice, "Don't you see a woman here with a child who needs help?" And the other passengers assented with their heads and their comments. The young man, somewhat embarrassed for his error in expected role performance, followed the woman's instructions and took the stroller and the bags and placed them outside the bus on the sidewalk. Then the mother passed the baby through the window to the young man so she could get off the bus.

Field work was not always an smooth experience, and a "smooth research experience" is certainly relative from one field worker to the other. Interviewing was at

times easy and pleasant and at other times difficult and annoying. Most women were willing to cooperate, but I encountered a few cases were the interviews were not so smooth. I, as many other anthropologists, encountered the difficulties of wondering if the informants were offering the most honest information or if they were providing misleading information. I had taken measures to create a questionnaire that was not threatening to the people. When the woman showed sings of feeling uncomfortable with some questions, for example the section on sanitary conditions where I asked for types of sanitary facilities that were available to her and her family, if the household did not have even a latrine, I sensed in several occasions that the informant would feel uncomfortable. In this situation I shared some of my own experiences growing up in a place similar to the places that I visited and under similar conditions. The exchange of experiences always eased the interview and relaxed the interview setting.

I also explained to each woman and to anyone who asked me on the streets of the communities the purpose of my visit to the communities and to some households and not others. I later learned that for locals in the communities it was very common to see people like me walking in the communities that I visited, often working for international agencies such as CARE, International Plan, or the PAHO. These agencies conduct demographic and health surveys in the communities which they use to develop health, economic, and sanitary projects in the communities. I was frequently asked if I was working for any of those organizations. The most common question that I encountered was, "Esta haciendo usted un censo para el Plan" (Are you conducting a census for the Plan?).

Other people thought that I was giving away bags containing rice, cooking oil,

tomato paste, beans, and instant chicken bouillon. Community members would ask me which political party I was representing, the blue and white, the red and white, or the purple and yellow. Most people's houses had one of the country's political party's symbol with the respective colors identifying their political party painted on a visible palce in front of their houses. I later learned that giving away bags containing food is a strategy used by politicians to gain the sympathy of voters.

In other occasions community members thought that I was a vendor coming from the capital city. Vendors usually come from the capital city but occasionally there are vendors that come from other large cities in the country. These vendors sell anything from medications to wall pictures and mirrors, underwear, children and adult clothes, and kitchen and household ware. Salespersons are commonly dressed in jeans, a T shirt, tennis shoes, a hat, and a back-pack where they carry their products. Coincidentally, I met the vendor's dressing stereotype.

Of all the women the most difficult group to interview was the agro-industrial workers. The first question these women asked me was if the company had sent me to investigate what they were saying about the company. Women feared that they would be fired if they said something against the company. Conditions for the workers at the interior of the company did not seem easy and contract agreements were in such a way that workers had little or no benefits and no job security. Unions are discouraged and unemployment rates are so high that, as a women pointed out, "they fire us today and there are 100 more women waiting for that job outside the company." For these reasons this group showed some suspicion at the beginning but disappeared relatively soon after I explained to them who I was and the purpose of my visit. Other women who I had

interviewed before also helped by telling other women that a Puerto Rican woman was around visiting some women and asking questions about health but nothing to worry about. "The company did not send her."

The interviews were surrounded by numerous experiences. My initial interview was conducted in the tomato fields while the woman was picking up tomatoes. I asked her if I could walk next to her to talk a little about health and work and she agreed to do so. I bent next to her for the next three hours. She answered my questions and talked to me about her job while I threw some tomatoes in her tin can. I found that this setting was rather difficult not only because we both were in an uncomfortable position, but because, even when the woman had agreed to be interviewed there, I was interrupting her working speed. In addition, the presence of other workers in the field was a distraction for me and the subject as well as I was a distraction for the other workers. Although the other workers were about 5 meters from where we were located, they were, as expected, interested in knowing the reason for my presence in the field.

As I mentioned before, during the interviews it was common that some curious neighbors would show up to ask what I was doing and if I would interview them too. In some instances they would stay and interrupt the interview by answering the questions I had asked the informant. I politely explained to them that, altough they had interesting opinions, I wanted to know what the person I was interviewing thought about what I was asking. In some occassions I spoke with them afterwards.

When I visited the households women often wanted to offer me something to drink, like coffee, but they seldom had and they would make an effort to get it from the little store and pay it latter. I myself felt uncomfortable when someone wanted to offer

me something to drink knowing that two pesos in coffee and two more in sugar was quite a burden for these households. I started buying little bags of coffee to take with me. When I arrived to the household, if the woman wanted to offer me something and was obvious that she did not have the means, I would offer the bag of coffee to the woman and we both would sit down and zip a cup of coffee while we talked about the issues of health and work, and about the general situation in the valley.

CHAPTER 4
WOMEN'S CONSTURCTION OF ILLNESS CAUSATION

Introduction

In this chapter I present what women said about their illness and about the context in which ill health develops. I discuss the relationship between women's health problems and the factors that women identified as influential on their health status in light of the organizing framework proposed in Chapter 2. The first component of this conceptual framework constitutes women's construction of illness causation. Illness events were reported in association with places of work, living conditions, economic situation, the environment, and social and economic roles. Women identified the workplace, communities, and households as places of exposure to risk factors.

One of the aims of medical anthropology is to understand individuals' perspectives about health and illness, the meanings that they confer to illness, and the ways in which they communicate and share the illness experience (Rommanucci-Ross 1983; Finkler 1997). The women surveyed described the concept of health as stages of illness from less severe to more severe or from acute to chronic conditions. Health, as a complete state of well being and absence of illness, the now familiar definition of the World Health Organization, was not a description that women gave about their perceptions of illness. The women interviewed appear to strive for the reduction of morbidities to regain partial health.

The original impetus of my research was to define a health and illness profile that considered women's health conditions in relation to their multiple productive and reproductive roles in society, a combination of factors infrequently examined in social science health research. However, an inductively derived categorization of women's explanations of illness causation revealed the importance of the influence of women's paid work on their health status. From women's construction of illness causation other categories emerged as well suggesting that women associated the experience of illness to their multiple economic and social roles. Also, influences such as the environment, their life styles and other family members' life style, family history, and economic conditions were part of the factors that women related as affecting their health status. In other instances, women explained a health problem as a health care provider explained it to them or as related to a pre-existing condition.

The dichotomization of productive-reproductive roles as a framework to explain illness, as I had originally intended, resulted incomplete to conceptualize other dimensions of illness causation that women regarded as factors influencing their health status. Women's explanations of ill health revealed a pluralistic system of illness causation (diversity of self-perceived factors acting simultaneously to the detriment of women's health status). Women did not speak of states of health or states of illness, but of a progression of illness. Absence of health was described as a progression from less severe to more severe forms of illness.

The women in the sample reported a variety of illness conditions and causes. Their illness diagnosis focused more on illness causation rather than underlying pathology. Some of the health problems reported by women would be medically

classified as symptoms. For the women interviewed the reoccurrence of the symptom had become the ailment on itself. The symptoms, however, can be indicators of a more severe condition or could be related to any of the other health problems that the woman reported, although identified as a separate condition. To discriminate among these is beyond the scope of this study. However, this information reveals a pluralistic system of illness causation where the women interviewed perceive illness as the result of exposure to different factors, in different settings, and while carrying out different roles. The women described the experience of illness as an accumulation of multiple conditions resulting from multiple causes or of various ailments as a result of a single factor. This illness profile might not be as visible through conventional biomedical methods that may overlook the individual in the context of her multiple roles and places of exposure because the focus is on the disease, its immediate causes, and manifestations.

After the introduction, this chapter describes the concept of illness as defined by the women interviewed. This description is followed by an overview of the research problem. For this I describe the different roles that women carry out during the day and the settings where those roles are performed. This section is based on the interview question that asked women to describe the different activities or tasks that they carried out the day prior to the interview and whether the description corresponded to a typical day of the week.

After the overview of the problem I present the health conditions that each group of women reported followed by a description of the risk factors that tomato pickers, banana packers, and agro-industrial workers identified in relation to their health problems. This section has been largely based on literature on occupational health of

farm workers in the Unites States and some examples from Latin America and Asia. The factors that women identified range from work-related to environmental risk factors.

As I show in this chapter, the data collected suggest that women perceive that factors associated to the types of work they perform are the main influence on their health status. Other factors such as the environment, life style issues, poverty, inheritance, and social roles were perceived as exacerbating ill health as well.

Women's Conceptualization of Illness: *Enfermedad, Estropeos, Maldades,* and *Quebrantos*

One of the contributions of medical anthropologists to the study of health and illness is the importance of understanding the way in which individuals explain illness and the cultural factors that shape their beliefs of illness etiology. Some classical anthropological examples are E. E. Evans-Pritchard (1937) study of witchcraft among the Azande or the well-researched topic of evil eye in Latin American societies.

Previous investigations about the experience of illness indicate that the cultural context where disease occurs shapes the way individuals experience illness. These studies have demonstrated the imperative of cultural beliefs (e.g. witchcraft, evil eye, and hot-cold humoral opposition) in defining causes of illness as opposed to the biomedical explanation of disease etiology as an organic dysfunction of the body organs and systems. The explanations that the women from San Felipe provided for the conditions that they chose to talk about focused on aspects of their everyday lives that are in the realm of social and cultural factors, ecological surroundings, and the economy of the region.

Throughout the discussion of this study I have referred to the health problems that women reported as illness, which corresponds to the individual's experience of being ill. The sociological and anthropological literature distinguishes between the concepts of disease, illness, and sickness. The concept of disease explains the abnormalities in the body as a physiological phenomenon. Illness is the experiential dimension of the physiological disorder explained by the individual and shaped by the larger cultural context and factors that influence the discomforting experience (Kleinman, Eisenberg, and Good 1978). The term sickness focuses on the social construction and responses to illness. Illness takes a social manifestation where the patient, family, and work "are being held responsible for one's failures or incapacity" and the individual gets well at the discretion of her "significant non-ill environment" (Gerhardt 1989:26). However, in the Spanish language the terms disease, illness, and sickness all translate as *enfermedad.*

As part of the interview schedule I asked women to define the concept of *enfermedad.* They defined illness in a functional way in terms of ability to carry on daily routines. Illness was the disruption of necessary activities. Illness was seen in terms of degrees of severity. Degrees of severity were also related to being functional.

The women interviewed explained illness as chronic conditions, "long sufferings that are always with you" and might require "going to the hospital and staying there." The women explained that they were ill if they "had to lay down and stay in bed", if "one is knocked down in bed without strengths and in pain," if "the body is in pain, one feels badly and dizzy." The women indicated that they were ill if they could not do household chores, and if they could not go to the fields, the packing sheds, or the processing plant. "When one is ill one does not do laundry or domestic work, one stays in bed." The

illness might require that the person is taken to the doctor. "Being ill is a preoccupation" because the individual might have to stop working.

Local expressions or idioms exist in different cultures as means to communicate and share the illness experience (Inhorn 1997). The women categorized their health problems in three types, (1) *estropeos*, (2) *maldades*, and (3) *quebrantos*. These idioms by no means incorporate all the range of local expressions that people in San Felipe utilize to explain or talk about illness, however, they are the expressions that the women interviewed utilized to speak about an ill event. Table 4.1 shows examples of these local idioms through which women communicated types of illness. These terms were used to refer to different ailments or symptoms of the ailment and indicate severity of the condition as perceived by the women in terms of duration, chronicity, or reoccurrence of the health problem.

Table 4.1: Examples of Health Conditions as Categorized by Women

Estropeos[1]	Maldades[2]	Quebrantos
1. cansancio (tiredness)	1. cuerpo caliente (hot body)	1. la presion alta (high blood pressure)
2. cansancio en la cintura luego de recoger tomates (lower back tiredness after picking up tomatoes)	2. dolor de cabeza (headaches)	2. problema en el corazón (heart problems)
	3. cabeza mareada (head dizziness)	3. problemas con el azúcar (sugar problems)
	4. gripe (cold)	4. infección vaginal (vaginal infections)

1 *estropeo:* to mess up; to ruin. In Spanish this term refers to making something worsen its aspect or its condition, for example, "el agua ha estropeado la madera" (the water has ruined ["estropeado"]the wood).
2 *maldad* as something wicked that hurts the person

Estropeos were described as tiredness and pains after long hours of work in the tomato fields or standing at the banana packing sheds. Maldades were described more as symptoms of a more severe health problem. These symptoms included body pains, dizziness, or strong headache. A *maldad* was described as less severe than a *quebranto* and more severe than an *estropeo*. It also lasts longer than an *estropeo*. A *maldad* could potentially lead to a *quebranto*. Quebrantos were described as a health problem that lasts for a "long time," "long enough to keep the person from not working at home or outside the house." Based on women's explanations, the term quebranto can potentilly disable the individual. This term also refers to chronic conditions such as heart problems, diabetes, and high blood pressure.

A woman explained that the *quebranto* could be taken care of by undergoing an operation or by staying on bed until the person is cured. A *quebranto* "is when one has a pain that last for a long time, an illness that lasts for a long time." Another woman explained that a *quebranto* could be "a headache that one has today and also tomorrow," "a suffering like high blood pressure, cholesterol, you always suffer," "an illness that lasts for a long time."

First Component of Organizational Framework: Women's Construction of Illness

I focused on women's responses to the question on what health problems had been experienced one month prior to the interview and what were the causes of the conditions reported. The findings suggest that the women interviewed construct illness as an experience shaped by the environment, social and economic roles, and their knowledge of biological factors.

Women identified six different influences on their health problems: work outside home or productive activities, work at home or reproductive activities, sanitary and living conditions, inherited health problems, behavioral or life style issues, and socioeconomic conditions such as low wages and unemployment, to which a woman referred as "illness of money." From these data I established four categories of health influences that emerged as dominant categories from women's responses to describe their health problems: occupational influences, economic influences, environmental influences, and social reproductive influences. Economic influences also include health problems related to nutritional status and little food intake. Social reproductive influences also include women's social reproductive roles and lifestyle or behavioral issues. Of these influences, the women in the sample identified work outside the home as the main cause of ill health. Table 4.2 illustrates the types of health influences and health problems described by women and that emerged from the data collected. Table 4.3 describes the types of health problems related to the general categories of musculoskeletal problems, respiratory problems, fatigue-like symptoms, reproductive system, and skin problems.

To examine the relationship between categories of factors and construction of illness I have utilized the biocultural model of health and illness with a greater emphasis on the economic context. The women established a clear association between ill health and paid work. Because of the strong association between illness and workplace, health problems linked to work outside the home merits special consideration. In lesser frequencies but no less critical, women identified household work, behavioral factors, environmental conditions, economic situation, and inheritance as causal factors for various of their health problems.

Table 4.2: Influences on Health and General Categories of Health Problems Associated with each Type of Influence

Occupational	Social reproductive roles	Economic	Environmental	Other
musculoskeletal	musculoskeletal	hypertension	respiratory infections	hypertension
fatigue-like symptoms	fatigue-like symptoms	anemia	dermatological problems	goiters
respiratory infections	chronic headaches	stomach problems	typhus	mouth infections
chronic headaches	vaginal infections	heat problems	vaginal infections	
stomach problems				
dermatological problems				

Table 4.3: General Categories of Various Health Problems and Examples

Musculoskeletal	Respiratory	Fatigue-like symptoms	Reproductive	Dermatological
lower back pains	coughs	dizziness	vaginal pains	skin spots
arm pains	colds	fainting	vaginal infections	skin infections
hip pains	bronchitis	tiredness	menstrual pains	skin rashes
body pains		lack of energy	hot flashes	skin itching
leg pains				
swollen legs				
swollen feet				
leg cramps				

Overview of the Problem: A Day in the Life of Women Tomato Pickers, Banana Packers, and Agro-industrial Workers

Maria, Juana, and Ana get up in the morning and begin their day making coffee, feeding the baby, preparing the other children to go to school, and taking care of the elderly mother or father. Maria gets ready and goes to the tomato fields where she will work until 2:00 or 4:00 PM. Juana gets to the banana packing sheds around 8:00 in the morning. Her time to return home is less predictable; it could be anywhere from 1:00 PM to 1:00 AM. Ana heads to the tomato processing plant where she will work until 3:00 or 4:00 PM.

Maria returns home in the afternoon and buys rice, beans, and some salad. If the money is enough she might buy some chicken, especially since the price of poultry went down at the time this fieldwork was conducted. With these items she prepares the main meal of the day for the family. Later on in the afternoon she takes a trail of peanut candy that she prepared the previous night and goes around the neighborhood selling candy. She, as well as other women, also makes pineapple, coconut, and milk candy for sale. Some women sell sweet bread and soft baked cookies (called *bombones*) and others sell milk. Those who can afford to sell fried chicken in the afternoon that is often accompanied with fried plantains, boiled cassava, plantains, or maize, and coffee. Juana will not get home until midnight. The European market has requested an order of the tropical organic fruit grown in the valley. Juana and the rest of the team have to load various *furgones* that will be shipped to Europe next day. The perishable nature of the commodity requires high-speed and intensive work. Ana might get home around 4:00 PM after spending a day selecting and washing tomatoes to be processed into tomato

paste. After she gets home, Ana takes a sharp machete and two big baskets filled with coconuts that she puts on her mule. She heads downtown, hoping to sell some coconuts to add a few more *pesos* to the family's income.

Every morning and afternoon these three women in their respective communities go to fetch for water at the river, the irrigation canal, or the next community where potable water is available. The communities where Maria, Juana, and Ana live have serious water problems. Water is a topic of daily conversation among Dominicans on the streets, their communities, at home, in the radio, and in the national and local newspapers: "*La falta de agua también golpea a Bani*", "*No es agua potable, es lodo*" (Listin Diario, April 1997); "*Miles de tareas están sin sembrar en San Felipe por la falta de lluvias*" (Hoy, April 1997.)

Fifty-three percent of the population in San Felipe lives in rural areas and 54 percent of this population do not have access to potable water (CONAPOFA/FNUAP 1995). The other 46 percent might have the infrastructure to allow access but do not necessarily have water in their communities in a regular basis. The water service is infrequently for both rich and poor; the wealthier segment of the population, however, can afford a water reservoir on top of their houses. Water is scarce in San Felipe.

Maria, Juana, and Ana are part of the 56 percent of the rural population in San Felipe who do not have access to potable water and of the 31.5 percent of all women interviewed who do not have access to water at all. These three women, as many other women in the valley of San Felipe, have on their daily schedule the task of fetching for water. Although 68.5 percent of all women interviewed indicated that they have access to potable water, this only indicates that their communities have been provided with the

infrastructure. There are differences in access to potable water between the three groups of women interviewed. Among the tomato pickers, 52.6 percent of the household have access to potable water, while 76.3 percent of banana packers' households, and 77.1 percent of agro-industrial workers households have access. It is important to indicate that 41.4 percent of the households visited own land or have access to land and that 20.7 percent of landowners are agrarian reform recipients. In addition, 32 percent of the women interviewed live in the urban zones. This is important because these data highlights the agrarian reform projects and the urban communities that have been provided with services such as potable water and electricity.

Pilar also works in the tomato fields. She takes her one-year-old child with her to the fields. I interviewed Pilar in the tomato fields around 11:30, during her late morning brake. The child was constantly crying while I was there. The mother asked the father to pour some water from the plastic container they brought from home to give to the baby, but the container was empty. The baby was thirsty and crying. The father took a bucket and walked towards the irrigation canal that runs on the side of the tomato field. He filled up the bucket with water. The mother gave some of the water to the child to drink. I observed in silence. She looked at me, smiled, and explained to me that she would give her parasite medicines when she got home after work. I wondered if she would in fact give the baby some parasite medicine if the baby did not show any signs of sickness. I thought about the other agents that were not parasites and were in the water that the child, the mother and the father drank. Participant observation revealed that the same water that is used for irrigation and runs through the fields after the fields have been sprayed with pesticides and/or fertilizers is also utilized for drinking, bathing, washing,

and cleaning.

The week is also loaded with tasks that are energy and time consuming such as firewood collection and clothes washing. Women carry heavy loads of both firewood and clothes on their heads. They might need to walk long distances, especially if water is not available in their communities. Firewood is the main source or fuel for 35.1 percent of the women interviewed and for 74 percent of rural Dominican women (MUDE 1996:6). The remaining 64.9 percent of the women interviewed have access to propane gas, although not all the cooking is done on the stove.

Most of the women in the sample are in common-law unions, a factor that limits their rights to properties and benefits. In 72.1 percent of the cases women are in free unions and only 3.6 percent of the women interviewed are married. Widows and women who have separated from their partners are more likely to lose any acquired access to material goods and other benefits from their previous partners when they are in common law unions. By impacting women's general living conditions and access to material benefits, marital status indirectly impacts women's health and well being.

How did the women in the sample talk about the causes of their illness? What situations and factors did woman identify as potentially harmful to their well being? In the next section I present the factors that women identified as limiting their health status and general living conditions. The health conditions are presented by group of women interviewed (tomato pickers, banana packers, and agro-industrial workers) and corresponds to the influences on health that they identified: occupational, economic, environmental, social reproductive roles, and others (Tables 4.2 and 4.3).

Health Conditions of Agricultural Workers

Women Tomato Pickers

In the San Felipe valley, the tomato-growing season begins in October when the fields are cultivated. By January a red blanket of ripe tomatoes will cover the fields and the tomatoes will be ready for the harvest. The tomato harvest season begins in January and ends around April. A woman tomato picker gets to the fields around 7:00 AM. Before she goes to the *conucos* (farms) she has started and finished a portion of her domestic chores: house cleaning, food preparation, water fetching; she has fed the smallest children and her parents or other older relative. Then she takes an empty tin can of *Crisol* vegetable oil and heads to the tomato fields where she works until noon, 2:00 PM or 4:00 PM, depending on the amount of tomato and the number of workers in the field that day. In the tomato fields she fills up between 10 and 75 sacs of tomatoes, 40 pounds each. The companies provide the sacs. Some women might fill up 100 or 125 sacs of tomatoes with the help of their children when they take them to the fields. The average woman interviewed fills up 40 sacs of tomatoes. She gets paid DR$1.00 peso per each sac filled up with nice, red tomatoes, the equivalent of US$0.07 cents at the time this fieldwork was carried out. The sacs can get emptied if they are inappropriately filled with tomatoes that are not completely red.

The tomato harvest lasts two to three months. Most women work two to three days per week. Based on my ethnographic observation and conversations with agronomists and farmers, it takes an average of two to three days to collect the tomatoes in one *parcela*. Farmers avoid leaving the tomatoes for more than three days on the plants because the tomato loses weight, the value of the tomato decreases, and they lose

money.

Women and children dominate the tomato harvest. Indeed, men prefer not to do this type of work and they indicate that women and children are better pickers than men because they can bend over and resist the long hours in the position required to harvest the tomato. A company's field supervisor stated that women and children are more patient to do a job that is repetitive, monotonous, and strenuous.

The tomato harvest requires that the worker bends over the low-lying plants to pick up the tomatoes. The tomato pickers spend long hours in this position in a field that ranges from 10 to 60 *tareas* of land (16 tareas = 1 hectare). The worker fills up the 40 pounds sacs, lifting and moving the sacs in short distances. Tomato pickers work in a rather fast pace because they get paid by the number of sacs they fill during the hours worked. The work ends as soon as all the tomatoes in one *parcela* are collected.

Head aches, musculoskeletal problems, respiratory infections, fatigue-like symptoms, and reproductive problems were the most prevalent health problems that women tomato workers reported. Skin problems and hearth problems followed these health problems. Musculoskeletal problems ranked first of all physical problems reported by women tomato pickers. The women interviewed related the musculoskeletal conditions reported to the bending posture in which they harvest the tomatoes, the long hours they spend in the field, and the sun. Other problems such as respiratory infections were related to environmental factors such as air, dust, and heat. Health problems of the reproductive system were related to behavioral issues such as alcohol consumption and promiscuity. Fatigue-like symptoms were related to long hours under the sun, little food

intake, and intensity of work. Table 4.4 shows the prevalence[3] of health problems among women tomato pickers[4].

Table 4.4: Prevalence of Health Problems Among Tomato Pickers

Health Problems	Number Reported	Prevalence
Musculoskeletal	23	60.5
Respiratory	12	31.5
Headaches	11	28.9
Reproductive	8	21.0
Fatigue-like Symptoms	8	21.0
Skin Problems	4	10.5
Stomach Aches	2	5.2
Heart Problems	2	5.2
Eye Problems	1	2.6
Hernia	1	2.6
Mouth Problems	1	2.6
Fever	1	2.6

n = 38

Women Banana Packers

Most of women's work in the banana-packing sector is performed in the packing

3 Prevalence of health problems was calculated dividing the number of each type of health problems that women reported at the time of the interview by the total number of women in each group of workers. Prevalence rates is one of the essential tools in epidemiological studies that "measures the number of people in a population who have the disease at a given time" (Mausner and Kramer, 1985:44). I have used this basic principle to measure the *accumulation* of illness among the women.

4 See Appendix B for a list of all health problems reported.

sheds. Male employees work in the field and outnumber female employees in administrative and technical positions.

The packing sheds are open areas covered with zinc sheds. A concrete box about 15 feet long and 3 feet tall and divided in two sections is built on the floor in the center of the packing shed. This box is filled with water. The water in the smaller section of the concrete box also contains a special chemical to remove the stain producing wax of the green bananas.

Women wear comfortable clothes, jeans, T-shirts, and, sometimes, open shoes. The are provided with an apron to protect their clothes from the banana stains. They work with bared hands. Women line up around the concrete box. The first group of women gets the bananas bunches from the men who bring the banana loads in trucks and separate the bunches from the stems. This group washes the bananas in the treated water that removes the wax. The women select the bananas according to color, appearance, size, and general condition of the fruit, and place the fruits in the next section of the box filled with clean water. The second group of women washes the hands of bananas in clean water, trim the crown in a rectangular shape with a sharp blade, and place the bananas on a trail to drain. The third group of women takes the bananas to the packing area where a fourth group of women has been placing plastic bags inside the boxes where the bananas will be packed. They carefully pack the bananas in boxes of 40 pounds each and move them aside where the team of men take over and load the trucks. Among the conditions reported by these group of women the most prevalent were musculoskeletal problems, respiratory problems, headaches, and fatigue-like symptoms. Table 4.5 shows the prevalence of health problems among banana packers. Most of the musculoskeletal problems of banana packers were related to work in the packing sheds. Respiratory

ailments were related to place of work as well as environmental conditions. Fatigue-like symptoms were mostly related to poor nutritional status.

Table 4.5: Prevalence of Health Problems Among Banana Packers

Health Problems	Number Reported	Prevalence
Musculoskeletal	15	39.4
Respiratory	10	26.3
Headaches	9	23.6
Reproductive	9	23.6
Fatigue-like symptoms	8	21.0
Eye problems	4	10.5
Fever	3	7.8
Skin problems	2	5.2
Stomach aches	2	5.2
Mouth Problems	1	2.6
hemorrhoids	1	2.6
Heart Problems	1	2.6
Goiters	1	2.6
Throat Infection	1	2.6

n = 38

Agro-Industrial Workers

In contrast to the tomato and the banana workers, women in the processing plant work in three different work shifts: from 7:00 AM to 3:00 PM; from 3:00 PM to 11:00 PM and from 11:00 PM to 7:00 AM. At the processing plant, women are responsible for washing and selecting tomatoes and other fruits, vegetables, and legumes. They are also responsible for the preparation, packing, and labeling of canned and bottled food.

Women explained being exposed to heat, chemical substances, and contaminated waters on the floors in the processing plant. They related skin problems such as nail fungus to these substances. Head aches and recurrent colds were reported in relation to early morning and late night work schedules. Several women explained that the night

shifts represent a dramatic change in their daily household routines. They reported that late night shifts are strenuous on their health.

Table 4.6: Prevalence of Health Problems Among Agro-industrial Workers

Health Problems	Number Reported	Prevalence
Musculoskeletal	22	62.8
Headaches	14	40.0
Respiratory	12	34.2
Fatigue-like symptoms	10	28.5
Reproductive	8	22.8
Fever	7	20.0
Stomach aches	3	8.5
Dermatological	3	8.5
Eye problems	3	8.5
UTI	2	5.7
High blood preassure	2	5.7
Parasites	2	5.7
Typhus	1	2.8
Abscess	1	2.8
Ulcers	1	2.8
Varicose	1	2.8
Sinusitis	1	2.8
Throat infection	1	2.8
Work accidents	1	2.8
Sugar problems	1	2.8
Nervios	1	2.8
Depression	1	2.8
Nose bleeding	1	2.8
Diarrhea	1	2.8

n = 35

Influences on Health

I have categorized the health problems reported by women as having four types of influences. Table 475 shows the four types of influences and the frequency of association of health problems with each category. Occupational influences refer to

those health problems that women explained in relation to their workplace (e.g. tomato fields, banana packing sheds, and processing plant). Social reproductive influences include health problems that women linked to domestic work and household maintenance. This category also includes behavioral issues such as male promiscuity and alcohol consumption. Behavioral issues are included as part of the social reproductive influences because the sphere of risk and exposure are the household setting and the domestic unit. In the category of economic influences I have included those health problems that women related to lack of income, poor wages, and poor nourishment as a result of little food available. Environmental influences refer to health problems that women related to factors such as poor sanitary conditions, lack of potable water, or contaminated air.

The results of this study show that illness is a recurrent event in the lives of the women interviewed. Most women reported having at least one health problem in the month previous to the interview or various health problems occurring simultaneously. The findings suggest that co-morbidity is one of the fundamental issues among the population studied (Table 4.7). Table 4.7 shows the number of health problems that women said they experienced 30 days prior to the interview.

Table 4.7: Number of Health Problems that Women Reported that they Had Experienced 30 Days Prior to the Interview by All Women and Group of Worker

Num. Health Problems	All Women		Tomato Pickers		Banana Packers		Agro-industrial Workers	
	no.	%	no.	%	no.	%	no.	%
0	12	10.8	4	10.5	8	21.1	0	0
1	32	28.8	11	28.9	12	31.6	9	25.7
2 – 3	50	45.0	20	52.7	14	36.8	16	45.7
4 – 5	13	11.7	2	5.3	4	10.5	7	20.0
6 +	4	3.7	1	2.6	0	0	3	8.6
Total	111	100	38	100	38	100	35	100

As I have indicated, work-related activities emerged as a dominant category over the other four types of influences. However, the health problems that were classified as pre-existing conditions and unknown causes also appear to dominate over the other types of influences recognized by women. The influences classified as "other" includes health problems that women explained as a result of a pre-existing condition such as arthritis or related to another health problem currently affecting the woman such as a mouth infection. In this category I have also included health problems that women related to pregnancy and conditions such as goiters.

In other cases, women said that they did not know the cause of a health problem. In this group are included health problems such as tooth aches, hot flashes, hemorrhoids, eye problems, chronic headaches, nerves, and typhus.

Table 4.8: Total Number of Health Problems Associated with Identified Types of Influence by All Women and by Group of Workers

Type of Influences	All Women		Tomato Pickers		Banana Packers		Agro-Industrial Workers	
	no	%	no	%	no	%	no	%
occupational	72	28.8	23	29.9	19	27.1	30	29.1
social reproductive	26	10.4	15	19.5	3	4.3	8	7.8
economic	11	4.4	1	1.3	4	5.7	6	5.8
environmental	26	10.4	11	14.3	5	7.1	10	9.7
other	42	16.8	15	19.5	10	14.3	17	16.5
don't know	61	24.4	8	10.4	21	30.0	32	31.1
none	12	4.8	4	5.2	8	11.4	0	0
Total	250	100	77	100	70	100	103	100

I examined the data to determine if the women interviewed considered a health problem that they reported related to workplace, social reproductive roles, economic conditions, environment, and other influences. Table 4.9 shows that, of the known reported causes of illness among all women, the workplace (occupational influences) has

the highest frequency of association. Workplace is followed by other causes, social reproductive roles, and environmental causes respectively. Similar associations are found among the three groups of workers.

Table 4.9: Individual Frequencies of Positive Association with each Type of Influence by All Women and by Group of Workers

Influences	All Women (N=111)		Tomato Pickers (n=38)		Banana Packers (n=38)		Agro-Industrial Workers (n=35)	
	no.	%	no.	%	no.	%	no.	%
occupational	56	50.4	20	52.6	16	42.1	20	57.1
other	28	25.2	11	31.5	5	13.1	12	34.2
social reproductive	23	20.7	12	31.5	3	7.8	8	22.8
environmental	23	20.7	10	26.3	5	13.1	8	22.9
economic	13	11.7	1	2.6	6	15.7	6	17.1
don't know	41	36.9	7	18.4	17	44.7	17	48.6
none	12	10.8	4	10.5	8	21.0	0	0

Risk Factors of Agricultural Work

In all three groups of women, tomato pickers, banana packers, and agro-industrial workers, the influence on health indicated most frequently was productive or work-related activities. In this section I describe the risk factors of agricultural work emphasizing the health problems to which the women interviewed are exposed. I have drawn from the literature available on occupational health of women agricultural workers in the United States, Latin America, and some examples from India and Japan.

Agricultural-related health problems cover a wide range of conditions: accidents, pesticides-related illness, musculoskeletal and soft-tissue problems, dermatitis, noninfectious respiratory conditions, reproductive health problems, climate-related illnesses, communicable diseases, urinary tact infections and kidney disorders, and eye

and ear problems. Among the risk factors to which women are exposed in agricultural activities are intoxication due to chemical pollutants within the working area, high levels of stress as a result of rigorous work schedules, which are often in conflict with the circadian rhythm, digestive problems, high temperatures, and parasitic infections, among others (McDuffie 1994). Studies report that women agricultural workers are also at risk of developing various cancers skin cancers, breast cancer, ovarian cancer, and lung cancer as a result of exposure to pesticides (McDuffie 1994; Wesseling et al. 1996).

The situation of agricultural workers is highly complex due to the temporary nature of their work. Research in this area shows that occupational health problems in agriculture are cumulative, as is the case of intoxication due to pesticides, and their effects are not immediately noticeable. These studies suggest that the seasonal and highly mobile nature of agricultural work could intensify pre-existing health problems making it more difficult to follow the trajectory of risk factors to which the worker might have been exposed (Mende and Riquelme 1994).

Certain conditions aggravate the health problems to which women in agriculture are exposed. The physical work that they do along with a poor nutritional status can increment such conditions as weakness often linked to under nutrition. Under nutrition has been associated with physical problems such as pains in the bones, joints, and muscles (Shatruga et al. 1990; Freudenber 1992).

Back aches, swollen feet and pains on legs are complications commonly found among women who work during the crop harvesting season in jobs that required standing and bending positions (Mendel & Riquelme 1994). Backaches are frequent among workers who perform repetitive manual jobs for long periods of time (Kapadia 1996).

Fatigue, dizziness, and musculoskeletal pains have been associated as well with work environments where employees have been exposed to high temperatures (Brabant 1992; Freudenber 1992).

In a study conducted in India among agricultural female workers the authors concluded that the back problems found among the population of women studied were strongly related to the postures in which they worked. The authors found that the occupational health problems of women were intensified by risk factors such as poor nutrition, frequent and early pregnancies, long working hours, and anemia (Shratuga et al. 1990). In another study in Japan, among strawberry and eggplant growers, the authors concluded that "physical symptoms such as fatigue and pain in the lower back and shoulders and tiredness, stiffness, and pain in the neck, shoulders, and arms" were related to posture patterns and muculoskeletal problems (Mobed, Gold, and Shenker 1992).

The women interviewed reported exposure to most of these health risks in their respective work settings. They associated 49.5 percent of their health problems to the types of paid work they carry out. with occupational influences having the highest toll on health indicated by all women. Indeed, musculoskeletal problems have the highest prevalence in the three working.

Ethnographic observations reveal that the women interviewed who work in the fields, the packing areas, and the processing plants, are exposed to accidents, chemical and biological agents, and to the development of a variety of conditions as a result of harmful postures, repetitive manual jobs, long work hours, and long standing positions. Women in the three working settings reported health problems associated with the

postures demanded during tomato harvesting, banana packing, or fruits and vegetables processing. They commonly reported pains in their limbs, swelling, and infections. Pains in hands and arms were linked to quick and precise movements harvesting tomatoes, cutting the crowns of the banana hands, and selecting fruits, vegetables, and legumes in the processing plant. Swelling and pains on legs and feet were related to standing positions for long periods of time. Banana packers and agro-industrial workers related hands, feet, and nail infections to stagnant waters possibly containing biological and/or chemical agents on the floor of the processing plants and the waters containing chemicals in the banana packing sheds. Other health problems linked to their work setting were: head aches, menstrual problems, varicose veins, waist, back, fatigue, tiredness, weakness, respiratory infections, and eye problems.

Environmental Influences on Health

Women also identified environmental factors as affecting their health status. The women that were interviewed live in crowded conditions with limited sanitation services and safe water. Respiratory problems, skin problems, health aches, and dizziness were related to environmental factors such the air, wind, dirt, sun, and water.

One woman commented, "I'm sure that where you come from you don't get these illnesses" ("*De donde u'te viene seguro que no le dan e'ta' enfermedade*"). Her knowledge of a better life in the island where I come from, Puerto Rico, based on the stories that people who migrate back and forth recount, made her conclude that the environment in my homeland, in contrast to the environmental surroundings of San Felipe, were clearly different. The air, for example, in is "cleaner" because there are no dirt roads in Puerto Rico, as opposed to San Felipe, or because the water is "not ill" ("*el*

agua no está enferma") as it is in San Felipe.

Other Influences

Other influences that women identified to explain their health problems include: pre-existing problems such as erysipelas, arthritis, and high blood pressure. Other influences included another health condition such as vaginal and mouth infections. They also indicated other influences such as walking with bare feet on the cold floor in the morning when the body is still hot, medications, negligence of mother when she was a young girl, menstruation, and falls.

Risk Factors of Social Reproductive Roles

During the formal interviews, women identified various aspects of their domestic roles that influence their health status: provision of food, child and elderly care, and household maintenance (provision of a healthy physical environment: washing clothes and household cleaning). Tasks related to food provision include getting firewood or charcoal if propane gas was not available, fetching for water, buying food or getting it from the farm, and meal preparation.

Most of these domestic chores require heavy lifting and bending postures, long-distance walking in some cases, and long hours of work. Health problems associated to these activities included back and body pains, headaches, and eye problems. The following words from the women illustrate this point:

> Sometimes when I am washing clothes or cooking I feel that my eyes are blurred. The back pains are because of tiredness and the stress of domestic chores.

> Some domestic chores make one sick. When I wash clothes with clorox and detergent, that makes my menstruation to come the next day.
>
> I have pains on the waist. One struggles a lot breaking a load of firewood; the nails get smashed.
>
> Pain on the hips because I was carrying dirt to [fix] the kitchen.
>
> When I wash clothes a lot I get pains on my back and my hips.

In this category of influences I have included health issues that are related to life-style issues. These influences are included here because the sphere of exposure and risk are the household and the domestic domain. In some instances women indicated that vaginal pains and infections were cause by their husband's sexual behavior. "I get vaginal pains; I've been told that my husband...he was with other women and he gave me that." "I have vaginal pains because of the man [the husband]." Health problems such as stomach pains were related to alcohol consumption and eating habits.

Risk Factors of Poverty

All the previous influences on health linked to the socioeconomic status of the group of women studied. There is a well-established link between poverty, unemployment, low-income, seasonal employment, low paying jobs and ill health. It has been acknowledged that socioeconomic status and health status are closely related. Researchers have found that there is a disproportionate distribution of illness and dead among individuals from different socioeconomic strata and that the costs of morbidity and mortality are higher among individuals lower in the SES hierarchy (Jacobson 1993; Sargent and Brettel 1996). Although these factors may no be the direct cause of illness, they are predisposing factors for the development of health problems.

Most of the women interviewed and their families live in what otherwise would be classified as overcrowded conditions, earn substandard salaries, and lack basic sanitary facilities. The temporary nature of agricultural work increases the uncertainty of income among these households that are dependent on agriculture and seasonal jobs. The seasonality of agricultural work and salaries forces women to exhausting work cadences. Low or lack of income rebounds on poor nutritional status and access to food resources. These constitute risk factors for health conditions such as anemia, malnutrition, or severe fatigue. What follows is a situation where women engage in a struggle to provide the basic needs. Their income capacity does not allow them to care for more than the provision of food for themselves and their families, at the expense of other areas such as health, education, adequate clothing and shelter, and general household health.

The women interviewed established a causal link between health conditions such as depression, stress, *nervios*, hypertension, lack of energy, and heart problems, and lack of income, poor paying jobs, unemployment, and seasonal agricultural employment. The following response from a women agro-industrial worker illustrates this point,

> "When I don't have anything to give to my children to eat, and I see my parents needy and I don't have anything to give them, that worries me " or "I don't have a stable job. This makes me feel restless, dimmed,"
>
> Malnutrition among the children and adults [is what you see around here] because very little is found to eat. When there are tomatoes one lives a little better.

Summary

In this chapter I have presented the construction of illness causation developed by the women interviewed with the aim of revealing the way in which a group of women contextualize and conceptualize illness. Illness was conceptualized in a progressive way from less severe to more severe forms of disease. The severity of the condition appeared to be dependent on the woman's ability to continue performing her daily activities such as household and agricultural work. Women's explanations of illness etiology reveal a pluralistic set of relationships among factors that adversely affect their health status. These factors include workplace and related activities, environment, economic conditions, social reproductive roles, and other influences such as inheritance. This pluralistic system of illness etiology can serve to inform the public health agenda about health problems of crucial importance to women that are not readily visible possibly due to a predominant public health discourse often dis-articulated from people's and communities priorities, other public health priorities or gender bias.

CHAPTER 5
WOMEN FACING ILLNESS

> The people...recognize the advantages of Biomedicine medicine and seek its drugs, surgery and hospital care, but contrary to what might have been expected, native doctors, prophets, and traditional consultations among kinsmen do not disappear with the adoption of Biomedicine medicine. Rather a modus vivendi has developed in which different forms of therapy play complementary rather than competitive roles in the thoughts and lives of people (Janzen, 1978).

Introduction

In this chapter I discuss the second component of the organizing framework proposed in Chapter 2: how women in the San Felipe valley cope with illness. The aim of this chapter is to present what the women in the sample indicated are the health care strategies to which they resort in the advent of illness. I discuss the health care resources that they use to prevent and treat illness given the availability of health care alternatives.

This chapter is organized as follows. First, I describe the sectors of health care that women identified as part of their health care resources: the biomedical system, traditional medicine, and medical pluralism, a combination of elements from biomedicine and traditional medicine. The concept of health care resources as it pertains to this study describes any type of health assessment, remedies, therapy, or intervention. This includes who is visited, the diagnosis, and the treatment or therapy recommended at the preventive or curative levels. In the second section of this chapter I discuss how the women interviewed cope with illness. This section discusses initial consultation, illness

diagnosis, and illness treatment. The women interviewed are not always capable of regaining health through the health care services provided by the public health system or through the healing strategies that are part of the medical tradition of their communities. In the same way, they are not in control of the environmental, cultural, or economic conditions that negatively affect their health status. Despite the uncontrollable, women seek the least state of illness through a combination of healing strategies.

Studies in medical anthropology have examined the existence of parallel medical traditions and their utilization by both seekers of health care alternatives and by practitioners of local medicine. This co-existence and utilization of parallel medical systems is known as medical pluralism (Leslie 1980; Cominsky 1982). People do not completely abandon their traditional medical systems as they learn more about the effectiveness of biomedical treatments and therapies (e.g. antibiotics, surgery, immunizations, medications) (Leslie 1980). In many societies, for instance, it has been found that "[t]he traditional connection between religion and healing weakens as evidence mounts that both the causes and prevention of disease can be understood in a secular framework" McElroy and Townsend 1989:344). This is not to say that in the San Felipe valley beliefs in supernatural causes of illness have disappeared with the advent of Western medicine. For example during my walks through the communities I often saw children wearing a red ribbon tied around their wrists or the bellies. I asked the mothers about the purpose of the red ribbon and they explained to me that a red ribbon protects children from becoming sick as a result of evil eye and bad wishes of other people for them having a healthy baby. This fear might not be surprising because infant mortality in this region is the highest in the country (CONAPOFA/FNUAP 1995).

When I visited one of my informants I saw that she had four small aloe plants

hanging from the ceiling of her house. I asked her if she was going to prepare a remedy with the plants since it is well know that the aloe plant has curative properties. She explained to me that the plants she had on her ceiling were to protect her family from illness such as a condition that would confine a family member to stay in bed due to a incapacitating disease or from misfortune such as not finding jobs or generating an income. She had five plants, one on each corner of her house and one hanging from the center of her hut to protect all entrances from evil spells.

With no intention of secularizing the curative experience of the women that I visited and interviewed, this chapter focuses on the therapeutic choices that the women surveyed employed from co-existing medical systems in the San Felipe valley to cope with ill health. During my interviews with them the topic of spiritual illness or supernatural causes of disease did not emerge as an explanation for the conditions that the women reported. This observation is not equal to non-existence of such beliefs. The lack of reference of supernatural or spiritual causes might be the result of the types of conditions that the women were reporting (e.g. body pains, stress, hypertension, heart pain, diabetes, vaginal infections) and the knowledge that they have acquired about the origin of these conditions through physicians, nurses, and pharmacists.

In facing illness, women in the San Felipe valley utilize both biomedicine and local medicine. Cominsky states that to many individuals there is no conflict between biomedicine and alternative forms of healing (1983:161) and many integrate both into a pluralistic system of health care choices. As one woman interviewed pointed out, "Sometimes their medicine [doctor's medicine] is better than one's medicine, but sometimes one's medicine is better than theirs." This is consistent with what the literature reports about pluralistic medicine in other cultures. For example, Stephen

Kunitz and Jerrold Levy (1981) found that the Navajo "use both native and modern therapies for the same illness because of the belief that modern medicine removes symptoms, while Navajo medicine cures the illness itself" (cited in McElroy and Townsend 1989:376).

In this chapter both biomedicine and local medicine are considered health care resources as suggested by the biocultural model of health and illness. Relatives and local healers within households and communities provide different forms of health care. Other forms of health care are provided by health promoters, nurses, and doctors in rural clinics, infirmaries, and the local hospital.

The concept of local or traditional medicine includes practitioners, healing practices, therapies, and remedies other than Western medicine. In the context of this study, local medicine includes practitioners such as *curanderos*, *brujos*, and *ensalmadores*, home remedies, medicinal plants, treatments and therapies, and health care provided by kinship members and friends. The professional health care sector includes the official, institutionalized medical system in the form of hospitals, rural clinics, medical professionals, medications, and therapeutic technologies.

Sectors of Health Care

Biomedicine: The Professional Sector

In the Dominican Republic most of the primary health care is provided by the public health care system. In San Felipe, public health care services consist of rural clinics, a regional hospital, trained doctors and nurses, and lay health promoters. The latter are lay people trained in the basics of preventive medicine and hygiene. The public

sector is composed of 29 facilities provided by the *Secretaría de Salud Pública y Asistencia Social* (SESPAS) (one regional hospital, three dispensaries, and twenty-four rural clinics) and one dispensary provided by *Instituto Dominicano de Seguro Social* (IDSS).

The primary health care system in the Dominican Republic is based on an array of regional hospitals and rural clinics administered by SESPAS. SESPAS constitutes the public health care system and provides most of the preventive health care to all citizens. This is the professional health care sector that women identified as part of the health services they utilize.

In addition to the SESPAS facilities, some women reported utilization of the IDSS, which requires a special public insurance plan and offers services to workers only. They also reported the utilization of nonprofit health centers that provide health care to the population. These health centers or infirmaries are subsidized through a combination of private, national, and international funds (SESPAS – EPP 1997).

Women also reported the utilization of private clinics, doctors' offices, and diagnostic centers requiring direct payment. In San Felipe, a collection of clinics, laboratory facilities, and offices of private doctors conform the private health care sector. Based on the information provided by informants, most of these facilities are located in the urban area. (CONAPOFA/FNUAP 1995).

Traditional Medicine

Local healers and home remedies that are not combined with pharmacological products are considered part of traditional medicine. Among the practitioners of traditional medicine that the group of women surveyed mentioned are *curanderos*,

brujos, and *ensalmadores*. Wilfredo Mañon Rossi (1983) indicates that in the Dominican Republic traditional medicine refers to medicine that is based on practices and beliefs that are generally accepted by the population and that are passed on from generation to generation. He states that *curanderos* and *brujos* performed differentiated functions and their knowledge is not available to the lay person (1983:11). Indeed, when I visited one of the local healers for an interview with him, he was reluctant to share with me his most common diagnosis and treatment, as did the health promoter, a nurse, and a physician that I interviewed. I visited Don Sixto, a 99-year-old healer from one of the communities with the purpose of informally interviewing him. I initially asked him about the concept of disease, the most frequent illnesses that he diagnosed among women, and the most common therapies and treatments that he recommended. He initiated his conversation explaining to me that he frequently sees women with vaginal pains or absence of menstruation. He explained to me that he prepares a *tomo*, a combination of plants and herbs in an empty rum bottle. He also explained to me that he sees people with arthritis and that he could cure this condition better than the physicians could. I proceeded to ask Don Sixto how he cured arthritis and amenorrhea. When I got to this question Don Sixto, "Ahhh, I cure it with a bottle." To this I asked, "With bottle, and, what does it have, how do you fix the bottle, how do you make it?" And Don Sixto said, "That cannot be said because then people won't believe on it anymore. But I make bottles not for drinking, because if you drink it you die, it's an unguent to rub with. Nothing of what I know I'm allowed to say. I've cured a lot of people." This incident is an example of how knowledge about indigenous medicine indicates is not immediately available to the lay person. This incident also showed me that to gain an understanding of the topic I was exploring with the local healer I needed more than a few visits to the community, a few

conversations with the *curandero*, and a local informant who was trusted by the people in the community. I needed to be there for a longer time in the good tradition of ethnographic research, but again, my purpose was not to describe healing systems, but to learn from the women about their health care alternatives.

Women indicated that the *brujos* posses supernatural powers and the healing rituals are part of a religious ritual. *Curanderos* have knowledge of curative properties of plants. Contrary to the *brujos*, they do not perform healing ceremonies. *Ensalmadores* cure massage therapies using oils and prayers. They also perform bone settling. Women explained that *brujos* are consulted if a woman needs to secure her husband , "Some women go there [to the *brujo* to secure their husband." *Brujos* are also consulted when it is believed that a witch has "sucked" a child. This is often a sign of severe diarrhea and parasitic infections (Vidal Campillo 1997, personal communication). One of the women that I interviewed explained to me that when she was five months pregnant her belly was very small for a five months pregnancy. She consulted a local healer and she told her that a witch was sucking her baby. The local healer made a remedy for her and cured the baby.

Medical Pluralism in San Felipe

Medical pluralism is the integration of elements from the local medical traditions and biomedicine by the practitioners and the recipients of local health care. This includes categories of illness and etiologies, and treatments employed to treat or cure patients. The health care resources that women use in the advent of illness is best described as a pluralistic system of remedies and choices of healers. Local healers as well as the women interviewed incorporate health care resources from both biomedicine

and local medicine. Biomedical practitioners, however, do not use local medical practices although women reported that in some instances doctors would recommend a home remedy such as the steam from eucalyptus leaves for congestion or other teas for stomach problems and common colds.

Pluralistic medicine plays an important role in health care as the initial response to health problems. Women play a dominant role in the provision of health care for themselves and their families. The utilization of herbs and home remedies characterizes the initial response to illness. Home remedies are made from plants, roots, tree barks alone or combined with animal derives (i.e. oils), pharmacological components, and other items such as the water pump's motor oil. Pharmacological products are easily found in local stores or *colmados*, and pharmacies. These remedies are utilized alone or in combination for a diverse range of acute and chronic conditions. These conditions range from a common cold and vaginal infections to arthritis and high blood pressure.

The women interviewed utilize biomedicine and local medicine, either serially or simultaneously, in response to ill events. The following quotes illustrate this point:

> "Before I go to the doctor one uses the home remedies that one has, if they don't work, one goes to the doctor."
>
> "I go to the doctor first, but if the doctor cannot solve the problem, I make home remedies."
>
> "If there are not medicines [in the rural clinic] for the cold one has to pick up leaves to make a tea and to take care of the cold because it is not only [the doctor's] medicine that cures."
>
> Sometimes one takes the child to the doctor but maybe it is not a problem of "doctors" what he has, what he has is a problem of "plants."

Local healers complete the group of health care providers that women of Azua indicated they might consult. These include *brujos*, *curanderos*, and *ensalmadores*.

These, however, were not indicated as those initially consulted. Except for several women, I felt that they did not feel comfortable sharing with me their believes in local healers and curative practices. This was especially true among urban women.

The women indicated that local healers are consulted when other forms have failed to address the health problem.

> Earth plants [plantas de la tierra] are particular. Not all illness are [cured with] plants from the earth. When they [doctors] don't find anything, one takes off and goes to find somebody else because they don't find anything that's a doctor's [work]. I mean, *brujos*.

Women indicated that they might consult local healers also for *ensalmos* and botellas. *Ensalmos* consists of massages on the area affected accompanied with prayers and oils. The women interviewed explained that ailments that often require an *ensalmo* are stomachaches, toothaches, nose bleeding, headaches, disjoint bones, and spider bites.

Botellas are a combination of tree bark, medicinal plants, and other substances that are usually made by a curandero or a brujo who has the knowledge of the medicinal properties of the plants that are appropriate for different types of conditions. The content of the *botellas* is not known nor revealed. The healer prepares the remedy based on what the person has told him her about the condition. Usually, the person has visited a doctor and the medical practitioners have diagnosed a specific disease, such as arthritis. When other forms of health care have failed women visit the local healer and tell him the condition that she is suffering. Based on this information, the local healer prepares a remedy. The content of the remedy is not shared by the curandero unless the individual is learning about the healing properties. As I explained earlier, *curanderos* are suspicious and they do not release information about their remedies and therapies unless the person is consulting with him for an ailment. Various women said that they had used *botellas*

for vaginal infections or for skin problems. They use them as baths or as a douche.

About Physicians' Attitude towards the Use of Home Remedies

I asked women, "Do you think that home remedies and traditional treatments could be used by doctors also and prescribed to people at the clinic or hospital?" Women answered with a diverse range of responses. Some indicated that it is not in the best economic interest of the doctors because they might make less money. Others suggested that doctors simply would not know what to tell an individual for a simple common cold because they do not have the knowledge that is needed about medicinal plants.

Women indicated that doctors do not like when their patients use home remedies, "They don't like when one uses home remedies." "Because they are doctors they are not going to explain to you how to make a tea for a child. They have their own medications and it is easier for them [to fill out a prescription] to give their medicine. But the home remedies one has to go to [woods or the mountains] get them, get the leaves and simmer them to make the tea." They explained that in some instances home remedies could be toxic and conflict with the medications that doctors have prescribed.

> They [doctors] might think that [home remedies] could harm the person.
>
> They won't guarantee you that a positive result from home remedies.
>
> They have medical samples to give away. They cannot give you home remedies because if there is a crash between the medicines they are not responsible if something happens.
>
> One cannot use *botica* medicine and earth plants [plantas de la tierra] together. If one takes a tea made from medicinal plants one has to wait to then take the medication because it can produce intoxication.

They also explained that medial doctors do not believe in home remedies: "The doctors don't believe in [home remedies], they believe in their medicines." "Doctors

don't like when one gives home remedies to the children. They say that [home remedies] don't cure." In other cases women indicated that doctors do not like when their patients use home remedies because they want the patients to go to their office or to buy the medications from their pharmacies.

> "The doctors don't accept that one uses home remedies, but one buys the medicine and it has the same leaves that one has at home."
>
> "They don't like that we use home remedies. What they want is that we go to them every time we have a little problem because that is how they make a living. The won't send one to just take a tea."
>
> "There are many remedies that one can use. A tea like the one that I had today won't harm anybody. But they [doctors] are not interested in one's recovery, they don't want you to get well too soon because they want the person to keep spending money in their pharmacy, and home remedies cure fast."
>
> [At the hospital] they ask one, "What medicine did you take?" and one tells them, "A tea." And immediately they react, they don't like it; they don't like it because one won't go to the doctor and they won't make money.

In other instances women explained that doctors do not know how to use medicinal plants: "If it is something that can be [cured] with plants, doctors cannot use them, someone who knows how to use them can use them. Doctors cannot use medicinal plants because they are doctors." Another woman stated that "the curandero can [prescibe] them [home remedies] but the doctor cannot." A woman explained that "there are many doctors that are peasants [that grew up in a peasant family and are from the rural area] but they won't tell you that." The woman explained that they know about medicinal plants and home remedies by virtue of growing up in an area where most people use them. She said, "if they are going to tell you about a treatment that one can use, they would have to do that in secret because there are many doctors that are "snobby" [to recommend traditional remedies]. Home remedies is [related] with people form the countryside."

However, various women also indicated that doctors may tell them to try other methods. For example, a woman explained that

> When one talks to a doctor about a home remedy they give you a hard time. If one goes to the hospital with a child who has diarrhea and is vomiting, you know that camphor is good for dizziness. But the doctors as soon as they smell the camphor they fight with you. But there are other doctors who would tell you to use them [home remedies]. They took a child to the Angelita [a hospital in the capital city] and they gave some sueros [intravenous oral rehydratation] and other things. But it was already 5:00 in the afternoon and the doctor said, "Go look if you can find somebody who would look at your child." I think he meant a *brujo*, and they looked for somebody and never again the child got sick."

Responses to Illness

What do the women interviewed do in the advent of illness? The findings of this study suggest that for the women interviewed local medicine plays an important role in household health care as the initial response to illness. Biomedicine is prevalent in San Felipe and women employ local and Western medicine together in a complementary fashion. They resort to biomedical treatments and doctors when home remedies have failed and vice versa. As a woman stated,

> Many times a medication from the earth [medicamento de la tierra] is better than the doctors' medication. I'm going to tell you about a syrup that they gave me at the rural clinic for coughing and it didn't work. However, I take a tea with anamú and eucalyptus leaves, cinnamon, lemon, limoncillo, and a mint candy inside and that cures my cough.

They resort to biomedical treatments and doctors when they can afford to pay them. They might resort to local healers, *curanderos* and *brujos* when biomedicine fails as a healing alternative. Pluralistic behavior was found at the level of illness diagnosis, consultation, and treatment. As I mentioned earlier, this is consistent with what researchers have found about what different cultures do in the advent of illness.

Initial Illness Diagnosis

The initial illness diagnosis was explored by asking the women how they knew that they were sick when they became ill or who told them that they were sick. The findings reveal that women effected the initial illness diagnosis in 91 percent of the cases while a doctor or other health care professional provided the initial illness diagnosis in only 3.6 percent of the cases. By group of workers, the initial diagnosis was also determined by the woman herself. Table 5.1 shows that there is not great variation in illness diagnosis by group of worker.

Table 5.1: Initial Illness Diagnosis

Diagnosticians	All Women (N=111)	Tomato Pickers (n=38)	Banana Packers (n=38)	Agro-industrial Workers (n=35)
woman herself	91.0	86.8	92.1	94.3
doctor/nurse	3.6	2.6	2.6	5.7
another person	2.7	2.6	5.3	0
missing data	2.7	7.9	0	0
Totals	100	100	100	100

Initial Consultation

The initial consultation was explored with the question, whom do you consult when you feel ill? Table 5.2 shows that the woman herself performed the initial consultation or a close relative, followed by a visit to a doctor from the public health care system. Table 5.3 shows a similar response to the initial consultation by group of worker.

Table 5.2: Who the Women Consult When They Feel Ill

Person Consulted	Women 15 to 65 (N = 111)	
	no.	%
a private doctor	7	6.3
a public doctor	44	39.6
a nurse	0	0
a health promoter	0	0
a curandero	0	0
women herself	30	27.0
a relative	27	24.3
a neighbor	3	2.7
Totals	111	99.9

Table 5.3: Who The Tomato Pickers, Banana Packers, and Agro-industrial Workers Consult When they Feel Ill

Person Consulted	Tomato Pickers		Banana Packers		Agro-industrial Workers	
	no.	%	no.	%	no.	%
private doctor	3	7.9	3	7.9	1	2.9
public doctor	10	26.3	17	44.7	17	48.6
nurse	0	0	0	0	0	0
health promoter	0	0	0	0	0	0
curandero	0	0	0	0	0	0
women herself	12	31.6	12	31.6	6	17.1
relative	10	26.3	6	15.8	11	31.4
neighbor (not relative)	3	7.9	0	0	0	0
Totals	38	100	38	100	35	100

As expected, there are discrepancies between what people say and what people do. During my conversation with the women some of them, especially tomato pickers, would overtly speak about their utilization of local medicine either in the form of home remedies or by attending a local healer. The banana packers and the agro-industrial workers, on the other hand would speak of home remedies as a tradition followed by older people such as their parents and grandparents, but that they no longer resort to local medicine. They emphatically indicated that they go to the hospital instead. Other

members of the household (older children present during the interview) would contradict what the mother had said indicating that they continue to use home remedies in the household, especially therapies that mix leaves, herbs, and roots for common colds, headaches, and upset stomach.

The percentages shown in Table 5.3 contrast with the national statistics on the distribution of individuals who consulted a biomedical health care provider or a local healer. The 1991 Demographic and Health Survey of the Dominican Republic shows that woman age 15 to 44 visited more doctors than any other health care provider or local healers (Table 5.4). The survey, however, fails to show the proportion of individuals who utilized self-care to respond to their illness. My survey shows that women from the same age group consult a doctor or other health care provider 46 percent (private and public doctors percentages aggregated) of the cases while they consult a lay person 54 percent (woman herself, relative, or neighbor percentages aggregated) of the cases. Other health care providers include nurses and health promoters. The 1991 Demographic and Health Survey (ENDESA'91) shows other professionals as being consulted (dentists, pharmacists.)

Table 5.4: Person that Women Consulted 30 Days Prior to the 1991 DHS Interview

Person Consulted	Women 15 to 45+	
	number	percent
Doctor	1516	94.1
Nurse	10	0.6
Dentist	27	1.7
Pharmacist	11	0.7
Health Promoter	0	0
Curandero	24	1.5
Other	16	1.0
Don't Know	7	0.4
Total	1611	100

Source: Demographic and Health Survey of the Dominican Republic, 1991, Table 4.04.

Initial Treatment

Table 5.5 shows that women initially resort to home remedies in response to illness relying on domestic care at the onset of illness. This initial healing response is not different by group of workers. Only tomato pickers appear to have a slightly higher utilization of home remedies.

Table 5.6: Initial Healing Response

Healing Response	All Women (N=111)	Tomato Pickers (n=38)	Banana Packers (n=38)	Agro-industrial Workers (n=35)
use home remedies	64.9%	79.9%	57.9%	57.1%
go to the doctor	28.8%	15.8%	34.2%	37.1%
other	4.5%	2.6%	0	2.9%
nothing	1.8%	2.6%	7.9%	2.9%
Totals	100%	99.9%	100%	100

Summary

The data shows that, for the group of women interviewed, the initial diagnosis and response to illness are carried out by the woman herself or by a close kin or neighbor. It also shows that the initial treatment response is conducted in the household resorting to traditional medical knowledge in the form of home remedies. While home remedies dominate the initial response to the event of illness among the three groups of women interviewed, they also effect the initial diagnosis of their health problem.

Utilization of traditional medicine, biomedicine, or both might be related in the case of women in San Felipe to economic resources and access to biomedical health care treatments and therapies. Also, they believe in the properties of traditional medicine and trust their knowledge of home remedies that they have acquired from the elderly.

In some cases women distrust the medications provided by the public health care system. The women surveyed often referred to them as *agüitas*, "little waters," implying that syrups and medications given at the rural clinics or at the hospital look like water, have been diluted, and are not strong enough to take care of their health problems. They also indicated that the health care system lacks enough doctors and facilities.

Women's utilization of home remedies and biomedicine does not always reflect a ranking of treatment preferences. The strategy is to use both in any combination based on what the person considers appropriate to treat or prevent an ailment. The ultimate goal for most of the women interviewed is to regain health.

CHAPTER 6
CONCLUDING SUMMARY

Introduction

The objectives of this chapter are to summarize the findings of this study, highlight key issues identified in this dissertation, and discuss the significance of this study for future research on women's health issues, women and work, and pluralistic medical systems in the Dominican Republic. As I indicated in Chapter 2, I have identified this dissertation as a woman-centric study. This study has been situated within the emerging field of women's health that has been set out as a multidisciplinary endeavor (nursing, medicine, sociology, anthropology, law, policy analysis) to address women's health issues in its broadest sense from a diverse array of theoretical, methodological, and practical perspectives (Dan 1994). A woman-centric study discusses the issues that affect women utilizing standards, methodologies, and research designs that deal with issues that are of special concern to women, in the case of this dissertation, women's illness and illness-coping strategies. A woman-centric approach also requires that women's experiences, "the ways in which they view and experience their illness, must be the basis for developing new knowledge in women's health. One consequence of [a woman-centric approach] is to focus our attention on understanding women's experiences, which have been omitted in many analyses of health issues" (Dan, Jonikas, and Ford 1994:388). This approach also requires the reconsideration and recognition of the information that the woman brings to assess her own health problems.

As it applies to this study, this approach has revealed how women integrate elements from their sociocultural, political, economic, and environmental surroundings to explain their experiences of illness and the risk factors linked to them.

Summary of Findings and Emerging Issues

This dissertation has centered on two main issues: (1) women's constructions of illness causation, and (2) the ways in which women cope with illness. This study was based on the premise that a woman-centric understanding of illness causation could provide insights into patterns of disease etiology and disease prevention and treatment. This knowledge could serve two purposes: one, it could enlighten theoretical discussions in medical anthropology about the ways in which individuals, groups, or communities contextualize and conceptualize illness processes and find ways to ameliorate ill health; and, two, it could serve to design health programs that could benefit individuals, groups, or communities by taking into account their own assessment of health needs and health care resources.

This study was conducted in the San Felipe valley, located in the Southwest of the Dominican Republic, among women who work in nontraditional agricultural jobs. I surveyed 111 women to explore their experience of illness and their perspectives about the causes of their health problems. I also explored what these women do in the advent of illness: Whom do they consult? Who determines the diagnosis? Where do they go to seek health care? What do they do in general to treat, cure, or prevent illness? The data on women's perspectives of illness causation and on their illness-coping strategies were collected with a health and work questionnaire. I also conducted ethnographic observations in the communities where women lived, and in the tomato fields, banana

packing sheds, and tomato processing plants where they work. The data gathered with this method served to complement the discussion of the central thesis of this study.

The findings of this study suggest that the constructions of illness causation of the women interviewed reflect a combination of factors related to their economic and sociocultural roles in society as well as to factors related to their ecological surroundings. The woman-centric approach taken in this study revealed a pluralistic system of illness etiology based on women's knowledge of occupational, environmental, economic, social, and cultural factors influencing their own health. Women identified workplace, communities, and households as places of exposure to conditions adverse to their health status. They identified environmental conditions, work outside the house, domestic chores, economic conditions, poor wages, unemployment, infectious diseases, and inheritance as sources of danger and illness. Among these factors, occupational settings, economic situation, and social reproductive roles appeared to be the most influential factors affecting women's levels of illness. The most prevalent health conditions found in the population studied and that were associated with the previous influences were: musculoskeletal problems, respiratory problems, headaches, conditions of the reproductive system, and fatigue-like symptoms.

How did women cope with illness? Women's illness-coping strategies combined traditional and biomedical healing practices and included practitioners of traditional medicine from their communities (*brujos, curanderos*) as well as from the biomedical health care system (health promoters, nurses, and doctors). Women indicated that they use biomedicine and traditional medicine serially or simultaneously. According to the women interviewed, and regardless of working group, the initial response to ill health was self-care with home remedies. This was followed by visits to a doctor from the

public health care system. These findings stress the importance of complementary health care resources in the midst of lack of alternatives and deficient biomedical services.

The findings of this study highlight other issues about women's health in the Dominican Republic, which have important ramifications for women in other parts of the Caribbean and Latin America. First, this study shows that illness causation was perceived as the direct and indirect result of larger problems in the communities, such as sanitary and environmental conditions, of work outside the home, their domestic chores, and the maintenance of households and families. This invites us to a re-evaluation of women's health to include those issues that they have identified as critical factors defining their health status. Also, the methodology employed in this dissertation stresses the importance of approaches to evaluating and understanding the health of individuals that include factors other than biological factors. Second, this study has argued in favor of a broader consideration of a research agenda on women's health that moves, at the levels of theory and practice, beyond women's biological reproductive health and population control programs. The perspectives of illness causation discussed in Chapter 4 support this argument.

Third, while continuing the tradition of studies that explores women's insertion in the labor force and its ramifications, this study highlights the important issue of how women's health has been affected by economic changes such as the increasing participation of women in the NTAE sector. This study brings to the forum the issues of women's health as workers in agricultural production, women's health and the new internationalization of labor, and women's health and the feminization of food production. These issues invite new theoretical as well as practical debates and further research that systematically explores the health consequences of these economic trends.

Fourth, the health of many Dominicans, especially of many women and children, has been severely affected by structural adjustment policies and the 1980s and 1990s economic crisis with direct effects on health resources through dramatic cuts of government expenditures on health (Whiteford 1993; Batista del Villar 1994). The existence of pluralistic medicine as source of health care might represent an alternative to the often economically unreachable biomedical health care resources. The experience of various communities in the Dominican Republic, which have conducted seminars and workshops about local medical practices through NGOs and community organizations, speaks about this. These communities have gathered their knowledge about traditional medicine in pamphlets and popular publications that can be used in their communities at the preventive and primary health care level (Polanco 1991; Polanco and Ramírez 1993; IMD, no date; Rodríguez and Colectivo Mujer y Salud 1994). These are examples of medical knowledge that individuals and communities are employing along with the public health care system and other forms of institutionalized medicine in an effort to provide health care alternatives for their families and communities.

Significance of the Study

In examining women's construction of the causes of ill health, this study attempts to contribute to the knowledge of risk factors that are recognized by individuals and associated with their multiple roles in society. Brems and Griffiths postulate that for women to benefit from health policies, programs, and research that can improve their health, the "health community must first benefit from women's voices" (1993:255). In practical terms, one the prospective ramifications of this bottom-up approach is that health concerns and needs defined within the community are more likely to translate into

fruitful research agendas and health programs. This pragmatic perspective can potentially result in a more effective diagnosis and treatment of local needs with long-term gains for women and their communities (1993:255). Along this line of thought, Janice Jiggins, in her book Changing the Boundaries, provides cases of successful projects where a woman-centric approach has influenced local and national policies about reproduction, fertility, and the spread of HIV/AIDS (e.g. The Bangladesh Women's Coalition, The Society for Women and AIDS in Africa-Nigeria).

While women's health in the Dominican Republic and other developing countries has been examined mainly within the context of fertility and maternal and child health, this study has shifted the focus to women's health needs in relation to other aspects of their daily life, such as their work at home and outside the home; sociocultural roles, environment, and economic conditions. In addition, this study has incorporated the methodological perspective of listening to women's experiences of illness and to the ways in which they cope with disease and other health disorders as a way to inform biomedical models of health assessment to define the social forces in disease etiology. Women's perspectives about the factors affecting their health status are important in establishing the parameters of influence from the individual's point of view in contrast to the public health system. These perspectives are often in conflict and unsuccessful programs are frequently the result of disagreements between perspectives.

The health conditions that the women interviewed described in relation to their workplace raises a new set of issues about women's health in the Dominican Republic and adds a different set of health concerns to the public health agenda that has traditionally focused on women's reproductive health and fertility control. These health issues are related to the types of jobs that women do in agricultural-related activities,

such as bending and standing for long hours, exposure to chemical and biological agents at the workplace, and conflicting work schedules for mothers that often impact the health of other household members, especially children. These concerns are related to low wages and working conditions and employment rights, but are also related to gender issues in the work setting and the jobs that are reserved to women versus men. With the increasing number of women being employed in the NTAE sector (Flores 1995; Kleysen and Campillo 1996), the omission of the risk factors that this economic sector poses on women's health constitutes an important gap of knowledge. In this context, women's experiences of illness and disability can be instrumental in establishing better health research agendas in occupational settings while illuminating existing health research methodologies to assess the health of workers. Finally, knowledge about the way in which communities that are influenced by and dependent on global economic shifts as well as by the transformation in health care resources and epidemiological profiles orchestrate new ways to defy illness can contribute to the development and design of better health programs for individuals and communities.

At a more specific levels, the findings of this study can aid in establishing the parameters of the influence of agricultural-related activities on women's health in the Dominican Republic, especially since more women who work in agricultural-related activities find jobs in the NTAE sector. These findings could inform researchers of salient features of this working sector leading to women's health problems. Although the NTAE sector is not representative of the entire range of agricultural economic activities in the country, the types of jobs that the women interviewed were performing (e.g. harvesting, packing, washing, selecting) are typical of the kind of work that women do in other crops (e.g. coffee and tobacco). The findings of this study concerning women's

health issues at the workplace can serve as a first step to establish the specific components of work in nontraditional agriculture that influence disability and disease risk. An example of this could be the high frequencies in which the women interviewed mentioned musculoskeletal problems and fatigue-like symptoms in relation to workplace compared to other conditions that they reported. The activities that women carry out in the fields, the packing sheds, and the processing plants certainly demand considerable physical effort which is often aggravated by other factors such as nutritional status and poverty.

In this study women identified a set of risk factors and health conditions within the context of their everyday lives. For example, agro-industrial workers reported respiratory problems in relation to the physical environment where they live but also to the physical environment where they work. As an organizing principle on both theoretical and pragmatic grounds, researchers and heath program developers alike can benefit from women's experiences of illness as they describe their conditions in relation to their everyday lives, which often include a set of activities that range from household maintenance and child rearing to income generating activities in both the formal and informal sectors of the economy. This should lead to "best identify the priority problems and points of interventions" (Brems and Griffiths 1993:255) to attain the goal of improving women's health status.

Although this study was not designed to determine the quantitative extent of the health problems that women reported, it provides a qualitative profile of the range of multiple factors that might be affecting women's health from the perspective of the women interviewed. Surprisingly, a glance at the public health data published for the region of San Felipe and adjacent provinces do not include various of the health concerns

that the women in the sample presented (e.g. chronic body pains and fatigue) (CONAPOFA AND FNUAP 1995). When the results of this study are compared with the results of studies conducted in other parts of the world addressing similar situations we find that the health concerns raised are strikingly similar. In the United States, for example, the National Institute of Occupational Safety and Health (NIOSH) has established eight high-priority research areas as part of the national health research agenda which includes allergic and irritant dermatitis, asthma and COPD, fertility and pregnancy abnormalities, hearing loss, infectious diseases, low back disorders, musculoskeletal disorders, and traumatic injuries (Hatch and Moline 1997). Interestingly, the women interviewed reported health problems of the categories of low back and musculoskeletal disorders in relation to the types of work that they do in the fields, packing sheds, and processing plants. Even when the data sets are different as a result of different research designs and methodologies, the similarities should be taken as a marker on the research agenda and as a cautionary signal of the ramifications of the exposure to similar working settings and types of jobs.

The results of this study can serve to set up a series of areas for further research and analysis and to qualitatively and quantitatively examine these issues qualitatively and quantitatively in other populations with similar characteristics. I wish to highlight the followings:

(1) the development of a specific exposure profile of women workers in nontraditional agriculture for the Dominican Republic;

(2) further research on how women's unpaid household work influence their health status;

(3) the importance of introducing data on women's social reproductive roles when assessing occupational risk factors; and

(4) the importance of understanding these areas and how they interact in order to enhance current knowledge of the nature of women's health problems and the distribution of them among Dominican women with similar demographic and socioeconomic characteristics.

Finally, I wish to highlight the potential of pluralistic medicine and women's health seeking strategies as a low-cost health care alternative in the midst of limited health care resources. With regards to this final point, I must indicate that my position is not to romanticize local healing systems or to argue for an integration of local medicine and Western medicine. My observations and the information that I gathered during my fieldwork lead me to suggest that there are important areas of research in the topic of indigenous medicine in San Felipe due to the apparent reliance of the women interviewed on traditional remedies, the combination of them with over the counter drugs or medications obtained from the communities' clinics, and the lack of confidence that the women interviewed expressed with regards to some aspects of the public health care services (biomedical services). The utilization of pluralistic medicine as a way to cope with illness among the women interviewed also invites further research on this topic and the health services provided to the population of the valley.

A Final Note

Women as researchers, activists, and community leaders throughout the world have engaged in the quest to develop better ways to assess and improve women's health. I strongly believe that as women's health and education improve throughout the world, the well-being of families and communities is destined to improve. My research has at its core a practical agenda, a quest for social justice and for one of the fundamental elements of human existence, the right to health. With this conviction, I join previous and current efforts to construct new ways to understand how women's well-being is impacted by changing economic, political, and environmental forces, oppressive sociocultural patterns, and devaluation of women's work.

APPENDIX A
CUESTIONARIO DE SALUD Y TABAJO

Fecha: ___/___/___
Entrevistador: _____
Tiempo duración: _____

I. Datos Demográficos y Socioeconómicos

❖ Voy a comenzar con unas preguntas generales sobre usted y su familia. Siéntase en la libertad de contestar aquellas preguntas incluidas en esta entrevista que usted así lo desee.

1. Nombre: _____
2. Lugar donde vive: _____
3. Edad: _____
4. Estado Civil:
   1. [ ] soltera 2. [ ] unión libre 3. [ ] casada
   4. [ ] separada 5. [ ] divorciada 6. [ ] viuda
5. Ultimo curso completado: _____
(indicar el número del último grado completado del 1 al 12 ó 13 para universidad, cursos técnicos o vocacionales)
6. ¿De cuántas personas está compuesta su familia? Todas las personas que viven, comen y duermen bajo el mismo techo. _____
7. ¿Podría proveer el sexo y la edad de todas las personas que viven, comen y duermen bajo el mismo techo?
8. ¿Qué tareas/trabajos hacía su padre para generar un ingreso? ¿Qué fue lo último que hizo su padre su ganar dinero?
9. ¿Que tareas/trabajos hacia su madre para generar un ingreso? ¿Qué fue lo último que hizo su madre para ganar dinero?
10. ¿Podría proveer la edad, el sexo y el tipo de actividad(es) económica(s) que realizan los miembros de su hogar?
11. Durante los últimos meses, ¿en qué usted ha estado ocupada la mayor parte de su tiempo?

	1	3	6	12
1. actividades pagadas en la casa	[ ]	[ ]	[ ]	[ ]
2. actividades pagadas fuera de la casa	[ ]	[ ]	[ ]	[ ]
3. actividades no-pagadas en la casa	[ ]	[ ]	[ ]	[ ]
4. actividades no-pagadas fuera de la casa	[ ]	[ ]	[ ]	[ ]
5 en todas las anteriores	[ ]	[ ]	[ ]	[ ]
6. otras, indique:				
7. ninguna	[ ]	[ ]	[ ]	[ ]

12. Durante los últimos meses, ¿cúales han sido o son las actividades económicas pagadas en las cuales usted ha participado? ¿Dónde, en la casa o fuera de la casa?

☞ Nota: Indicar C = en la casa / F= fuera de la casa. al extremo izquierdo de la contestacion. Si la entrevistada trabaja en la parcela o conuco de la familia del cual se genera un ingreso, considerar esta actividad como remunerada en la casa; si la entrevistada tiene una tiendita en la casa o que es parte de la casa donde vende víveres o artículos misceláneos, considerar esta actividad como remunerada en la casa; si la entrevistada cuida niño en la casa y le pagan, considerar esta actividad como remunerada en la casa.

	1	3	6	12
{ } 1. agricultura	[ ]	[ ]	[ ]	[ ]
{ } 2. industria	[ ]	[ ]	[ ]	[ ]
{ } 3. servicios domésticos	[ ]	[ ]	[ ]	[ ]
{ } 4. chiripeando (actividades informales)	[ ]	[ ]	[ ]	[ ]
{ } 5. otras, indique:	[ ]	[ ]	[ ]	[ ]

15. En los últimos meses, ¿cuáles han sido o son las actividades económicas no-pagadas en las cuales usted ha participado?¿Dónde, en la casa, fuera de la casa?

☞ Nota: Indicar C = en la casa / F = fuera de la casa, en la comunidad, barrio, vecindario al extremo izquierdo de la contestación.

		1	3	6	12
{ }	1. cuidado de niños y ancianos	[ ]	[ ]	[ ]	[ ]
{ }	2. cuidado de enfermos	[ ]	[ ]	[ ]	[ ]
{ }	3. cuidado de adultos incapacitados	[ ]	[ ]	[ ]	[ ]
{ }	4. mantenimiento del hogar	[ ]	[ ]	[ ]	[ ]
{ }	5. preparación de alimentos	[ ]	[ ]	[ ]	[ ]
{ }	6. compra de alimentos	[ ]	[ ]	[ ]	[ ]
{ }	7. cultivo de alimentos	[ ]	[ ]	[ ]	[ ]
{ }	8. crianza de animales	[ ]	[ ]	[ ]	[ ]
{ }	9. trabajo en el conuco	[ ]	[ ]	[ ]	[ ]
{ }	10. otras, indique:	[ ]	[ ]	[ ]	[ ]

14. ¿Me podría decir cuáles fueron las diferentes tareas que usted hizo ayer desde que comenzó el día temprano en la mañana hasta que termino? ¿Es éste un día normal de la semana?
☞ Nota: Usar página provista al final para esta pregunta. Ver instrucciones adjunto.
15. ¿Cuál es su ocupación principal?
    15.a. ¿ Fue éste el último trabajo que usted tuvo?
        1. Si [ ] 2. No [ ]
16. ¿Cuántas personas de su hogar ganan dinero?
17. ¿Qué tipo de actividad realizan para ganar dinero y como le pagan?
☞ Nota: diario=D semanal=S quincenal=Q mensual=M por ajuste=PA
18. ¿Qué se comió ayer en la comida?
    1. [ ] arroz 5. [ ] pollo, cerdo o res
    2. [ ] habichuelas 6. [ ] víveres
    3. [ ] fideos/spaguetti 7. [ ] ensalada
    4. [ ] huevos 8. [ ] trigo
19. En su opinión, ¿quién cree usted que debe alimentarse mejor en su familia? ¿Por qué?
20. ¿Tienen ustedes tierra?
    1. [ ] Si 2. [ ] No
21. La tierra que ustedes poseen es:
    1. [ ] de reforma agraria
    2. [ ] arrendada
    3. [ ] heredada
    4. [ ] comprada
    5. [ ] tierra a medias
    6. [ ] recuperadas/invadidas

(54). Su casa es [ ] propia [ ] alquilada [ ] prestada
22. Su casa, ¿tiene luz? 1. [ ] Si 2. [ ] No
23. Su casa, ¿tiene agua potable? 1. [ ] Si 2. [ ] No
24. ¿Qué tipo de servicios sanitarios tiene su casa?
    1. [ ] inodoro individual 2. [ ] letrina individual 3. [ ] letrina colectiva 4. [ ] otro
25. Materiales de construcción de su casa:
    1. [ ] block 2. [ ] cemento 3. [ ] asbestos 4. [ ] concreto armado 5. [ ] zinc 6. [ ] palma
    7. [ ] cartón 8. [ ] lata 9. [ ] madera 10. [ ] tejamanil 11. [ ] tierra 12. [ ] otro
26. ¿Cuántos aposentos tiene su casa?
27. Este hogar tiene:

    1. [ ] licuadora 2. [ ] nevera 3. [ ] plancha 4. [ ] abanico 5. [ ] radio 6. [ ] estufa (marque aquí ( ) si cocina con leña) 7. [ ] televisor 8. [ ] lavadora
28. ¿Tiene animales? 1. [ ] Si 2. [ ] No
    Indique animales y número:

II. Morbilidad e Incapacidad

◆ El grupo de preguntas que le voy a hacer ahora tienen que ver con su salud y la salud de su familia.

29. ¿Tiene usted o ha tenido algun problema de salud o alguna enfermedad en el último mes? ¿Desde

cuándo tiene este problema? ¿Cuál es la causa? ¿Cómo supo que tenía este problema? ☞ Nota: Tomar historial de duración y causa de las condiciones de salud que indique la entrevistada.
30. ¿Ha estado usted enferma o con alguna molestia a causa de alguna de las actividades antes mencionadas?
☞ Nota: Revisar las diferentes tareas previamente mencionadas.
1. Si [ ] 2. No [ ]
2. (si contesta No pasar a la # 31)
30a. ¿Cuáles son esos problemas de salud que usted ha tenido y desde cuándo se siente así o tiene este problema y cuál ha sido la causa?
31. ¿Qué otros problemas de salud usted ha tenido, desde hace cuánto tiempo y cual creee usted que es la causa de que usted se sienta así, de que tenga estos problemas de salud?
32. ¿Ha estado usted limitada por alguna condición de salud que usted padece? ¿le ha impedido continuar realizando sus actividades en el hogar, en su comunidad o en su trabajo?
1. Si [ ] 2. No [ ]
33. ¿Cuál es o cuáles son esos problemas de salud?
34. ¿Cuál es la condición de salud que mas le afecta, que mas le ha limitado?
35. ¿Cuál es la limitación principal que le ha causado esta condición de salud?
36. En general, ¿cómo usted describiría su salud?
1. Buena 2. Regular 3. Mala
¿Por qué? Explique.
37. De todos los problemas de salud que usted a identificado, ¿cuál es o cuáles son los que mas le preocupan? ¿Cómo están relacionados con los diferentes quehaceres que usted realiza?
38. ¿Ha estado algún miembro de su familia enfermo o con alguna molestia a causa de las actividades/quehaceres que el/ella realiza?
1. Si [ ] 2. No [ ]
38a. ¿Cuáles son esos problemas de salud que sus familiares tienen o han tenido, desde cuándo y cuál es la causa?
☞ Nota: incluir parientes consanguíneos y afines y miembros del hogar que no guarden ninguna relación de parentesco.
39. ¿Qué otros problemas de salud han tenido los miembros de su hogar?
(edad/sexo /problemas de salud/ duración / causa)
40. ¿Ha estado algún miembro de su hogar limitado por alguna condición de salud? alguna enfermedad le ha impedido continuar sus tareas/quehaceres en la casa o fuera de la casa?
1. Si [ ] 2. No [ ]
41. ¿Cuál es o cuaáes son los problemas de salud que mas le han afectado a los miembros de su hogar?
42. ¿Cuál es o son las limitaciones principales causadas por este problema de salud a los miembros de su hogar?
43. En general, ¿cómo usted describiría la salud de su familia?
1. Buena 2. Regular 3. Mala
¿Por qué? Explique:

III. Utilización de Sistemas de Salud Nativos y Biomédicos

◆ Las preguntas que le voy a hacer ahora tienen que ver con que hace usted cuando se enferma usted o algún otro miembro de su familia.
44. Cuando usted se ha enfermado, ¿cómo supo o quien le dijo que usted estaba enferma?
45. ¿Cuándo usted se empieza a sentir mal, qué es lo primero que usted hace?
1. [ ] usar remedios caseros
2. [ ] usar medicina tradicional
3. [ ] nada
4. [ ] otro, indique:
46. ¿A quién usted consulta o a dónde va cuando se siente enferma?
1. [ ] a un doctor
2. [ ] a una enfermera(o)
3. [ ] al promotor de salud de la comunidad
4. [ ] al curandero de la comunidad
5. [ ] voy ir a la clinica rural

6. [ ] voy al hospital de Azua
7. [ ] voy a un médico privado
8. [ ] llamar al médico del barrio
9. [ ] otro, indique:

47. ¿Cuál es la facilidad médica mas cerca de usted?
    47.a. ¿Cuán lejos esta de su casa?
    47.b. ¿Es publica o privada?
    47.c. ¿Usted lo utiliza normalmente?
    47 d. Si usted no lo utiliza, ¿podria decirme por qué?
48. Inventario de remedios y tratamientos caseros
(remedio/ que cura/ para que lo usa/ como lo aprendió/dónde lo aprendió)
49. Cuando usted o algún otro miembro de la familia se enferma, ¿qué remedio(s) usa y a quién(es) consulta?

IV. Preguntas Adicionales (hacerlas antes de las preguntas de cierre)

50. Sobre el concepto de enfermedad: Cuando uno se enferma, ¿qué le pasa a la persona? ¿qué es enfermarse? ¿enfermedad?
51. ¿A dónde van las personas de por aquí cuando se enferman?
52. ¿Cuáles son los servicios de salud que hay aquí en su comunidad?
    a. clínicas rurales
    b. hospital
    c. promotores de salud
    d. brujos
    e. curanderos
    f. personas que sepan poner inyecciones
    g. personas que sepan dar primeros auxilios
53. ¿Dónde se compran las medicinas?
54. ¿Cuáles son las enfermedades mas frecuentes aquí en la comunidad? ¿De qué la gente se enferma con mas frecuencia?

V. Sección de discusion abierta: Las mujeres opinan sobre los servicios de salud pública

❖ En la siguiente sección me gustaría saber que usted opina sobre los servicios de salud que hay aquí en su comunidad. Comencemos por repasar lo que hay: clincas rurales, un hopital en San Felipe, centros de distribución de anticonceptivos y servicios ambulatorios.

☞ Nota: Revisar con la entrevistada el tipo de servicios y facilidades médicas que hay al servicio de ella.

55. ¿Cómo usted describiria los servicios de salud y las facilidades médicas que hay en su comunidad y en San Felipe?
    1. [ ] Buenos 2. [ ] Regular 3. [ ] Malos

¿Me podría decir por que son _____?

56. ¿Cree usted que los remedios y tratamientos que ustedes utilizan para curar sus enfermedades en la casa podrían ser utilizados en las clinicas, hospitales, centros de cuidados, dispensarios o enfermerías? ¿Por qué?
57. ¿Como cree usted que podrían mejorarse los servicios de salud que usted tiene disponibles?

VI. Preguntas de Cierre

58. Ahora quisiera saber si usted tiene alguna pregunta sobre esta entrevista que hemos tenido, sobre alguno de los temas de los que hemos hablado hoy o cualquiera otra inquietud que usted tenga.
59. Ahora me gustaría saber si usted estaria interesada en participar en una reunion con otras mujeres de aqui de San Felipe para dialogar en grupo sobre algunos de estos temas. Por ejemplo, cuando nos reunamos vamos a discutir temas tales como plantas y remedios caseros, los servicios de salud que hay aquí en San Felipe y la salud de las mujeres en general. ¿Le interesaría participar? 1. Si [ ] 2. No [ ]

APPENDIX B
LIST OF HEALTH PROBLEMS THAT WOMEN REPORTED

1. Headaches
2. Stomachaches
3. Lower back pains
4. Arm pains
5. Body pains
6. Hip pains
7. Vaginal pains
8. Menstrual cramps
9. Cerebral pains
10. Leg pains
11. Foot pains
12. Toothaches
13. Feet "heat"
14. Dizziness
15. Fainting
16. Coughs
17. Colds
18. Heart pains
19. Hernia
20. Tonsillitis
21. Swollen legs
22. Swollen Feet
23. Mouth infection
24. Fever
25. Nails' infection
26. Hands' infection
27. Tiredness
28. Abscess
29. Nerves
30. Diarrhea
31. Depression
32. Typhus
33. Goiters
34. Skin rashes
35. Skin spots
36. Hot flashes after menstruation
37. Virus
38. Nose bleedings
39. Tachycardia
40. Bronchitis
41. *Pujos*
42. Hemorrhoids
43. Hot flashes
44. *Piquiña* (skin itching)
45. Urinary track infections
46. Parasites
47. Ulcers
48. Sinusitis
49. Varicose veins
50. High blood pressure
51. Throat infection
52. Accidents
53. Leg cramps
54. Anemia
55. Lack of energy
56. Sugar problems

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BIOGRAPHICAL SKETCH

Zobeida Enid Bonilla Vega was born on May 14, 1969, in Cayey, Puerto Rico. She received her Bachelor of Arts degree from the Recinto Universitario de Cayey, Universidad de Puerto Rico in Cayey, Puerto Rico, in 1991 in social sciences with an emphasis in sociology. She completed her Master of Arts degree in cultural anthropology at Colorado State University in Fort Collins, Colorado in 1994. During her doctoral studies, Ms. Bonilla received support from the Department of Anthropology as a teaching assistant and the College of Liberal Arts and Sciences. She received her doctoral degree in anthropology from the University of Florida in 1998, with an interdisciplinary focus in medical anthropology and women's health issues in Latin America and the Caribbean. Her academic interests include health issues of Latinos in the United States, health issues of women agricultural workers in the Caribbean, health issues of migrant farm workers in the United States, and public health policy. She is currently a post-doctoral investigator in a joint project between the Department of Special Education, University of Florida, and the Graham Porter Center for Child Development, University of North Carolina in Chapel Hill. She is working with Latino families with children with disabilities looking at coping and adapting mechanisms of these families, and evaluating access to educational and health services.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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Professor of Anthropology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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